Legal Advocacy Toolkit – Table of Contents

This toolkit contains the following helpful resources for HIV Legal Collaborative attorneys. This collection is not exhaustive, but highlights some of the most frequently used resources. We encourage you to use the Resource Bank, a comprehensive database of quality memoranda, research, reports, legal guides, court and agency decisions, pleadings and briefs, policy analyses and recommendations, and other materials on topics of importance to people living with HIV and their advocates.

Ending and Defending Against HIV Criminalization: State and Federal Laws and Prosecutions, Vol.1, CHLP's Positive Justice Project, First Edition, Fall 2010 (Updated through 2012)
The Center for HIV Law and Policy has released the first comprehensive analysis of HIV-specific criminal laws and prosecutions in the United States. The publication, *Ending and Defending Against HIV Criminalization: State and Federal Laws and Prosecutions*, covers policies and cases in all fifty states, the military, federal prisons and U.S. territories. The catalog of state and federal laws and cases is the first volume of a multi-part manual that CHLP's **Positive Justice Project** is developing for legal and community advocates.

Chart: HIV, STIs and Relative Risks in the United States, Center for HIV Law and Policy, 2011
This chart presents data comparing HIV infection to other sexually transmitted infections. These data illustrate that other sexually transmitted infections can pose similar, and sometimes equally great or greater, risks than HIV. Herpes simplex virus type 2 (HSV-2) and human papilloma virus (HPV) are more prevalent than HIV. Gonorrhoea and HPV are far more easily transmissible than HIV during unprotected sexual activity. Like HIV, HSV-2 is not curable. Potential consequences of HPV, gonorrhoea, and HSV- 2 include cancer, pelvic inflammatory disease, infertility, and infant death.

Transmission Routes, Viral Loads and Relative Risks: The Science of HIV for Lawyers and Advocates, Center for HIV Law and Policy, 2011.
This document summarizes key scientific sources and selected quotations on the nature of HIV in ways that are accessible and useful for legal briefs and other advocacy work. The publication includes sections on HIV as a chronic disease, HIV as an impairment of the immune system and a covered disability under the ADA/ADAAA, the routes and risk of HIV transmission, and the use and limits of phylogenetic analysis in proving the source of an individual's HIV infection. While this resource is intended primarily to support those working against HIV criminalization or representing persons with HIV in criminal proceedings, it should be useful in a variety of civil or legal proceedings in which the nature of HIV or how it is transmitted is at issue.

Chart: HIV and Chronic Disease in the United States, Center for HIV Law and Policy, 2011

This chart presents data on the prevalence, impact and treatment of HIV infection with parallel data on chronic diseases such as cardiovascular disease, diabetes, and Hepatitis C. This chart allows for the comparison of HIV to other chronic diseases that are common in high-income countries and that require lifelong clinical management. This data is not intended to diminish the personal and societal consequences of HIV infection, but to draw awareness to the equal or greater toll of other chronic diseases.

Employment Rights of People Living with HIV/AIDS: A Primer, The Center for HIV Law and Policy

The primer outlines the state and federal laws that prohibit employment discrimination on the basis of HIV, the elements of a case challenging HIV discrimination, additional protections against gender and race-based employment discrimination, and international human rights laws that apply to employment and the rights of people with HIV/AIDS to work and equal job opportunities. The primer also addresses the different requirements for HIV-related employment discrimination cases produced by the Americans With Disabilities Act Amendments Act that went into effect last year.

Housing Rights of People Living with HIV/AIDS: A Primer, The Center for HIV Law & Policy

One in a series of primers on various legal issues as they pertain to people living with HIV/AIDS, this primer on housing law provides guidance on the laws protecting people with HIV from housing discrimination and ensuring their ability to find safe and stable housing. The primer focuses on the Fair Housing Act as it relates to tenants with HIV/AIDS, and provides information on Housing Opportunities for Persons with AIDS (HOPWA) and other federal housing assistance programs. The primer also provides information on the effect of past criminal activity on the ability to secure federal housing assistance. In March 2010, the Primer was updated to include a section on how U.S. advocates can use international human rights law to support a person with HIV's right to safe, stable, and affordable housing.

A Guide to Disability Rights Laws, U.S. Department of Justice, Civil Rights Division
Laws covered in this guide include, but are not limited to: the Americans with Disabilities Act (ADA), which prohibits discrimination on the basis of disability in employment, state and local government, public accommodations, commercial facilities, transportation, and telecommunications; the Fair Housing Act, which prohibits housing discrimination on several bases, including disability, race, and sex, in private housing, housing that receives federal financial assistance, and state and local government housing; and the Rehabilitation Act, which prohibits discrimination on the basis of disability in programs conducted by or receiving financial assistance from the federal government, in federal employment, and in the employment practices of federal contractors.

HIV/AIDS Testing, Confidentiality & Discrimination: What You Need to Know About New York Law, Legal Action Center (2012).

This is an updated manual by the Legal Action Center on New York State's HIV testing, confidentiality, and discrimination laws. This version has been updated to reflect new state and federal laws, and provides detailed discussions of New York's HIV testing and confidentiality law, HIPAA's federal health privacy rules; and anti-discrimination laws that protect people with HIV/AIDS. While the resource is primarily useful to health, service, and legal providers within New York State, there is also information provided about federal privacy protections.

Medicaid: A Primer: Key Information on Our Nation's Health Coverage Program for Low-Income People (The Kaiser Commission on Medicaid and the Uninsured, June 2010).

This guide provides comprehensive information on Medicaid, the nation's publicly funded health coverage program for low-income Americans. It describes the persons and services covered, costs related to the program, and how the program is financed. The guide closes with a discussion of how the Affordable Care Act will reshape Medicaid, namely that the program will expand to provide the foundation for coverage of low-income Americans.

Access to and Quality of Medical Treatment: Federal Cases, The Center for HIV Law & Policy

This circuit-by-circuit compilation provides citations and holdings for federal cases concerning access to and quality of medical treatment in prisons. The compilation focuses on cases dealing with the medical treatment of inmates living with HIV, and primarily concerns claims alleging that the lack of health services available violated prisoners' Eighth Amendment rights.

Reference Guide to HIV as an ADA Disability, David W. Webber, AIDSandtheLaw.com (2011).

This reference guide, originally published April 2011 by David W. Webber on AIDSandtheLaw.com, provides a listing of Americans with Disabilities Act provisions (as amended in 2008) along with parallel Equal Employment Opportunity Commission regulations (as amended in 2011) – both with pin-point citations – relevant to establishing HIV as a disability under the ADA. The Reference Guide is intended to accompany the essay, *EEOC's New ADA Regulation: What Does it Mean for People with HIV?* and should be particularly helpful to practitioners.

Sample Affidavit for HIV physician. Impact of disclosure on relationship

PositiveJusticeProject

ENDING & DEFENDING AGAINST HIV CRIMINALIZATION
A MANUAL FOR ADVOCATES:

VOL. 1

STATE AND FEDERAL LAWS AND PROSECUTIONS

FIRST EDITION
FALL 2010
With additional laws and cases through June 2012

René Bennett-Carlson, Managing Attorney
Daniel Faria, Legal Intern, Summer 2010
Catherine Hanssens, Executive Director

MISSION STATEMENT

The Center for HIV Law and Policy is a national legal and policy resource and strategy center for people with HIV and their advocates. CHLP works to reduce the impact of HIV on vulnerable and marginalized communities and to secure the human rights of people affected by HIV.

We support and increase the advocacy power and HIV expertise of attorneys, community members and service providers, and advance policy initiatives that are grounded in and uphold social justice, science, and the public health.

We do this by providing high-quality legal and policy materials through an accessible web-based resource bank; cultivating interdisciplinary support networks of experts, activists, and professionals; and coordinating a strategic leadership hub to track and advance advocacy on critical HIV legal, health, and human rights issues.

To learn more about our organization and access the Resource Bank,
visit our website at www.hivlawandpolicy.org.

To contact us:
Email us at info@hivlawandpolicy.org.

Or write to:
The Center for HIV Law and Policy
65 Broadway, Suite 832
New York, NY 10006
212.430.6733
212.430.6734 fax

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Completion of this publication was supported by grants for CHLP's anti-criminalization work and our Positive Justice Project from MAC AIDS Fund and Broadway Cares/Equity Fights AIDS.

FOREWORD TO VOLUME I

This volume represents the first installment of a multi-volume resource for responding to the phenomenon of HIV criminalization. Future volumes and editions will include resources such as check lists for attorneys and other advocates, sample affidavits and other documents for cases that go to court, and additional analysis of the history and purpose of criminal and civil law punishments targeting people affected by HIV.

Because statutory law and common law trends develop and can change over time, we anticipate future editions of this volume to reflect such changes. However, while we made every attempt to include relevant cases as they existed at the time of publication, it is important to keep in mind that it is possible that we are significantly under-reporting the occurrence of HIV-related arrests and prosecutions in the United States. States do not share the same systems for tracking arrests across all counties and areas of the state, and many arrests are unlikely to appear in news reports or databases readily available to the general public or researchers.

A NEW STRATEGY TO END CIVIL AND CRIMINAL PUNISHMENT AND DISCRIMINATION ON THE BASIS OF HIV INFECTION

From the beginning of the HIV/AIDS epidemic, stigma and fear have fueled mistreatment of people living with HIV. One of the more troubling and persistent issues for people with HIV has been the prospect of criminal prosecution for acts of consensual sex and for conduct, such as spitting or biting, that poses no significant risk of HIV transmission. The Positive Justice Project is CHLP's response to this issue: a truly community-driven, multidisciplinary collaboration to end government reliance on an individual's positive HIV test result as proof of intent to harm, and the basis for irrationally severe treatment in the criminal justice system.

The use of criminal law as a way to stop or slow HIV transmission invariably is ineffective. The reasons why individuals take risks with their health, and how they assess risk, are many and complex. Arresting and prosecuting people with HIV for consensual sexual relationships or no-risk conduct, such as spitting, does nothing to take these reasons into account, or to assess risks based on the specific circumstances of the case at hand, such as viral load or even basic issues of intent or mutual responsibility.

We believe that success in reducing and ending reliance on criminal laws to single out and stigmatize people with HIV; educating court, prosecutors, and media; and in lessening stigma and discrimination, begins with a focus on the very real and serious public health ramifications of HIV criminalization. This in no way involves abandonment of civil liberties principles, but rather broadens the focus of advocacy to the public health consequences of ignoring individual rights.

A multi-pronged and collaborative plan is needed to address HIV criminalization, including a focused cross-disciplinary conversation about reconsidering the way we conceptualize and talk about HIV and transmission risk. Goals of our Positive Justice Project campaign include:

- Broader public understanding of the stigmatizing impact and negative public health consequences of criminalization and other forms of discrimination against people with HIV that occur under the guise of addressing HIV transmission.
- Community consensus on the appropriate use of criminal and civil law in the context of the HIV epidemic.
- Clear statements from lead government officials on the causes and relative risks of HIV transmission and the dangers of a criminal enforcement response to HIV exposure and the epidemic.
- A broader, more effective community-level response to the ongoing problem of HIV-related arrests and prosecutions.
- Reduction and eventual elimination of the inappropriate use of criminal and civil punishments against people with HIV.

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INTRODUCTION

This volume sets out the specific laws and illustrative cases in each state and U.S. territory on the treatment of people with HIV in the criminal justice system. Also included is a summary of military prosecutions of individuals with HIV, and the treatment of HIV as an aggravating factor under federal sentencing guidelines.

First, this volume and the individual state analyses it contains were carefully researched and current as of the date of publication. The law is fluid, however, and users always should check for the subsequent legal or legislative developments. The statutes and cases collected here are fairly comprehensive and will provide the reader with a good sense of how individuals living with HIV have fared under the criminal laws and enforcement policies in their states. The cases were identified through searches of press archives, internet searches, and case and news reports on Westlaw. In our search on Westlaw, we used successive search terms in various databases with HIV and either criminal charges and/or modes of transmission, such as "HIV," "assault," "spit," etc., to identify court decisions and media reports. Although we have attempted to include all reported cases from either news media sources or official judicial opinions, not all cases of HIV exposure are reported in the media and many prosecutions do not result in published judicial opinions. As a result, the cases represented here are assumed not to constitute an exhaustive representation of all HIV-related prosecutions in the U.S. The cases presented are likely only a sampling of a much more widespread but generally undocumented use of criminal laws against people with HIV.

Second, this volume attempts to collect only those laws and state cases that explicitly, or by clear implication, have or can be used to prosecute people for conduct on the basis of HIV status. In some states, this has included general criminal laws that are not HIV-specific, including offenses such as:

- Reckless endangerment;[1]
- Assault;[2]
- Terroristic threats;[3] and
- Homicide and attempted homicide.[4]

[1] Typically, *reckless endangerment* is defined as recklessly engaging in conduct which places or may place another person in danger of death or serious bodily injury. Model Penal Code § 211.2 (1985). *Recklessness* is defined as a conscious disregard of a substantial and unjustifiable risk. § 2.02(2)(c). Consent is not a defense to reckless endangerment because, under the Model Penal Code, consent can only be a defense when the threatened harm is "not serious." § 2.11(2)(a).

[2] Typically, *simple assault* is defined as an attempt to cause, or purposely, knowingly, or recklessly causing bodily injury to another. Model Penal Code § 211.1(1) (1985). The crime also includes negligently causing bodily injury to another with a deadly weapon. The crime becomes an *aggravated assault* if the actor causes or attempts to cause "serious" bodily injury, or if he or she knowingly or purposely causes or attempts to cause bodily injury with a deadly weapon. § 211.1(2).

[3] Typically, *terroristic threat* is a communication, either directly or indirectly, of a threat to commit any crime of violence with intent to terrorize another or otherwise cause terror with reckless disregard of the risk of causing such terror. *See* Commonwealth v. Walker, 836 A.2d 999 (Pa. Super. Ct. 2003) (affirming conviction on basis that defendant's statements were intended to cause terror from fear of HIV infection, likelihood of actual HIV infection resulting from threatened conduct is immaterial).

[4] Typically, *homicide* can either be *murder* (a homicide committed purposely, knowingly, or with extreme recklessness), Model Penal Code § 210.2 (1985), *manslaughter* (a reckless homicide), § 210.3. or *negligent homicide* (a homicide committed negligently), § 210.4. *See also* § 2.02 (general requirements of culpability: definitions of "purposely," "knowingly," "recklessly," "negligently"). Homicide offenses relating to HIV transmission are rarely prosecuted, except as attempted offenses, because it is unusual for transmission of HIV to result in death. Homicide prosecutions are also unusual because of the requirement of proof of causation and proof of intent to transmit HIV, particularly in sexual contact

Although these general criminal laws could, theoretically, be used against people living with HIV in all states, we only include case reports about them where they in fact have been applied to cases involving HIV.

This volume does not include analysis of the many state laws that mandate HIV testing of suspects arrested and/or convicted of sex offenses, some with negative consequences for those who test positive. We also do not address the very real, increasing problem of confidentiality violations, in which public health, health care, and other service providers share the HIV status of individuals in their care with law enforcement officials, sometimes after counseling them to avoid sexual contact without prior partner notification, in the belief that these individuals pose a risk to others and that health and service providers have a legal or ethical "duty to warn."

Many states have "communicable" or "contagious disease" control statutes that criminalize STI exposure, which may or may not include HIV.[5] Most of these statutes were enacted prior to the discovery of HIV and have typically not been enforced against any person with an STI or HIV. The penalties under these statutes tend to be limited to misdemeanors and there is no record of a case of HIV exposure ever being prosecuted under such statutes. Due to the antiquated nature and limited use of these statutes, such communicable disease statutes were not highlighted in this manual except in cases where HIV is noted within the scope of the statute. For states that have an HIV-specific criminal statute in addition to a communicable disease control statute (i.e.: California, Tennessee, etc.), the latter was not highlighted or analyzed.

The state-by-state section references but does not include a exhaustive analysis of all instances of sentencing determinations that, even without HIV-specific sentencing statutes, were or could be influenced by a defendant's HIV status, or a victim's allegation that the impact of a crime included fear of exposure to HIV. Such cases typically concern rape survivors who, after learning of a defendant's HIV-positive status, or other infection with an STI, may have begun to take preventative medication, or feared possible infection with HIV, or have become alienated from family members. These factors can be material to a sentencing court's consideration of the "impact of the crime upon the victim ... including a description of the nature and extent of any physical, psychological, or financial harm." In these cases, courts and juries might treat the "physical and emotional trauma" as constituting a level of harm beyond that of a "typical" rape victim.[6]

An additional area of law that is not addressed here in depth, but is of potential concern to people with HIV and their advocates, is the option of civil commitment available to government officials seeking to isolate individuals with HIV, or to continue to confine persons with HIV whose conviction can be characterized as a sex crime. There are two types of these laws of concern to

cases. *aff'd* State v. Schmidt, 771 So. 2d 131 (La. Ct. App. 2000) (affirming conviction and sentence of 50 years at hard labor in attempted homicide prosecution based on defendant's having intentionally injected victim with HIV), *prior opinion,* 699 So. 2d 448 (La. Ct. App. 1997) (pre-trial writ opinion ruling on admissibility of DNA evidence).

[5] *See e.g.* CAL. HEALTH & SAFETY CODE § 120600 (West 2010); LA. REV. STAT. ANN. § 40:1062 (2008); MONT. CODE ANN. § 50-18-112 (1989); N.Y. PUB. HEALTH LAW § 2307 (McKinney 2001); S.C. CODE ANN. § 44-29-60 (2009); TENN. CODE. ANN. § 68-10-107 (2010); VT. STAT. ANN. TIT. 18 § 1106 (1973); W. VA. CODE § 16-4-20 (2010). There has never been a prosecution for HIV exposure under any of these statutes. Prosecutions for HIV exposure, if any, have arisen out of the general criminal law or HIV-specific exposure statutes of these states.

[6] *See* e.g., Torrence v. Commonwealth, 269 S.W.3d 842, 845-46 (Ky. 2008); State v. Scott, 180 P.3d 774 (Utah Ct. App. 2008).

people with HIV and their advocates. The first are general civil commitment laws, available to health and law enforcement officials in every state, that allow for the involuntary commitment, typically to a mental health or medical facility, of individuals determined to be a danger to the public or to themselves. Under this type of law, an individual who comes to the attention of a public health officer who believes the individual is behaving in a way that threatens disease transmission can be subjected to a petition and court order confining the individual for a period of time until the supposed risk of harm no longer exists. The other type of law authorizes the confinement of individuals determined to be sexually violent predators, i.e. persons who have been convicted of or charged with a sexually violent offense and who suffer from a condition affecting emotional or volitional capacity such that they pose a menace to the health and safety of others.

The United State Supreme Court has upheld the use of involuntary civil commitment or confinement of individuals, although the use of this measure has certain requirements to remain within the bounds of the federal Constitution.[7] Such measures have been used against persons with HIV in recent cases suggesting that a defendant's history of unprotected sexual contact (as admitted by a defendant or evidenced by his contracting a sexually transmitted infection such as gonorrhea or syphilis) without disclosure of his HIV infection is adequate to meet the statutory dangerousness standard for confinement.[8] A more recent, and perhaps more pernicious trend, is the indefinite detention of persons with HIV under sexually violent predator confinement statutes. Such statutes were upheld by the Supreme Court in *Kansas v. Hendricks*[9] and have been applied to persons with HIV based on sexual activity posing no risk of HIV transmission.[10]

In virtually every state and case situation, state and local prosecutors possess significant discretion in determining whether and how to prosecute individuals arrested or reported for HIV exposure. It is important to keep in mind that particular jurisdictions with significant numbers of prosecutions may be as reflective of a prosecutor's mindset or ambitions as it is a product of a particular state law. However, it is difficult to include assessment of this factor in a publication of this kind. Obviously, we cannot report on cases that prosecutors have declined to prosecute, and, to our knowledge, no prosecutor has developed public guidelines for use in determining whether prosecution is appropriate or not (some prosecutors might, as some cases suggest, select only cases in which there are multiple partners involved in sexual activities that present at least an actual risk of transmission, where the defendant has been explicitly warned that his behavior if continued will result in prosecution, where actual transmission of HIV seems to have taken place, or where a defendant has evidenced an intent to transmit HIV – cases that from a law enforcement point of view present more egregious circumstances and greater ease of conviction).

Similarly, the overly broad statutes that criminalize, as we point out in our analysis, conduct that presents little or no risk of HIV transmission, might be narrowed in their application by appropriate prosecutorial discretion. But even if a prosecutor declines to prosecute a specific case, being the

[7] *See* Foucha v. Louisiana, 504 U.S. 71 (1992); Addington v. Texas, 441 U.S. 418 (1979). For a discussion of civil detention of individuals with HIV who pose a risk of transmission, see Ronald Bayer & Amy Fairchild-Carrino, *AIDS and the Limits of Control: Public Health Orders, Quarantine, and Recalcitrant Behavior*, 83 Am. J. Pub. Health 1471 (1993) (finding very limited use of civil detention measures and advocating instead for education, counseling, voluntary testing and partner notification, drug abuse treatment, and needle exchange programs to prevent HIV transmission).
[8] In re Renz, No. A08-898, 2008 WL 4706962 (Minn. Ct. App. Oct. 28, 2008).
[9] 521 U.S. 346 (1997).
[10] In re Coffel, 117 S.W.3d 116 (Mo. Ct. App. 2003) (reversing civil confinement order after three years of confinement as a sexually violent predator based on underlying criminal offense posing no risk of HIV transmission).

subject of a law enforcement investigation of HIV exposure can have significant negative impact on the life of someone with HIV. The statutes we analyze thus present a significant risk of harm to persons with HIV who in fact may not have engaged in behavior that is a prosecutable offense.

Our analysis is not able to capture fully whether defendants with HIV are given fair trials or whether, because of the social stigma that attaches to their status as HIV-positive in what are often emotionally charged allegations of betrayal within deeply intimate relationships, their own truthful testimony is discounted, or their defense counsel are less than zealous and well-informed about the underlying medical and scientific issues.[11]

Defendants in such cases also may not have adequate access to expert scientific witnesses. Indeed, some convictions of persons with HIV appear to the be result of so-called expert testimony that is nothing more than "junk science" that unfortunately is relied upon by judges or juries, even in those cases where the defense seeks to challenge and discredit it. Nevertheless, given many of the "facts" as found by judges or juries in these cases, there is certainly support for the view that the testimony of defendants with HIV is often discounted, particularly in cases where conflicting testimony is from law enforcement personnel who are likely to be viewed sympathetically by the fact-finder and whose social standing is superior to that of the defendant,[12] such as those testifying that they were spit upon or bitten by an HIV-positive defendant in their custody, or for the "morally innocent" sexual partners whose trust has allegedly been betrayed by the nondisclosure of HIV status by a sexual partner.[13]

In our summaries of cases, which include both reports of cases in published judicial opinions as well as in news media sources, we include as many relevant facts about the defendant and the case as possible, but without making any judgment about how one might interpret those facts.[14] For example, in many cases, information about the HIV status of the defendant's sexual contact or contacts is included. As we explain, proof of transmission to a sexual partner is generally not an element in most cases. Often, however, while it is either implied or explicitly stated that the defendant is the source of a sexual partner's HIV infection, there is often little if any information about how the defendant, as opposed to another sexual partner, has been established as the source of that infection.

Finally, under many HIV-specific statutes, particularly those imposing enhanced penalties for prostitution offenses, cases can be prosecuted under attempt or solicitation theories, and no evidence of a completed offense is necessary for conviction. Under these often overly broad statutes, as we note, no sexual contact or other activity posing a risk of HIV transmission is

[11] *See, e.g.*, State v. Bird, 692 N.E.2d 1013 (Ohio 1998) (affirming conviction based on defendant's no contest plea which was deemed an admission of factual issue as to whether saliva can be a deadly weapon because of risk of HIV transmission).

[12] *See, e.g.*, People v. Hall, 124 Cal. Rptr. 2d 806 (Cal. Ct. App. 2002) (affirming HIV testing order on theory that sweat on defendant's hands might pose a risk of HIV transmission to prosecutor who defendant assaulted during his criminal trial).

[13] *See, e.g.*, Ginn v. State, 667 S.E.2d 712 (Ga. Ct. App. 2008) (affirming conviction in case that resulted from the defendant's former sexual partner applying for an arrest warrant with magistrate court and giving a statement to sheriff's department against the defendant for failing to inform him of her HIV status, although her HIV status was published on the front page of a local newspaper before she commenced the sexual relationship).

[14] In regard to news media reports, we caution the reader that the actual facts may differ significantly from those as reported, given the potential for sensationalized reporting on such cases. Nevertheless, we include these news reports because in many cases there is no other published source of information about the case.

necessary, and often court opinions offer scant information about the actual risk of HIV transmission that would have resulted from the offense, had it been completed.

STATE BY STATE GUIDE

Alabama Statute(s) that Allow for Criminal Prosecution Based on HIV Status:

ALA. CODE § 22-11A-21(C)

Penalties for person afflicted with sexually transmitted disease for transmitting such disease to another person

Any person afflicted with an STD who knowingly transmits, assumes the risk of transmitting, or does any act which will probably or likely transmit such disease to another person is guilty of a Class C misdemeanor.

HIV included among STDs, *see* ALA. ADMIN. CODE r. 420-4-1-.03(2008).

Class C misdemeanors are punishable by up to three months in jail.

Alabama has prosecuted incidents of HIV exposure under general criminal laws.

Under Alabama's communicable disease exposure statute cited above, HIV-positive persons may be imprisoned for up to three months or fined up to $500 if they "knowingly" transmit the virus, assume the risk of transmitting, or perform any act which will probably or likely transmit such disease to another person. [15] Neither the intent to transmit HIV nor actual transmission is required.

Though HIV/AIDS is classified as a sexually transmitted disease for the purpose of Alabama's statute there has never been a prosecution for HIV exposure under this law. Many states[16] have similar communicable disease control statutes, but their applicability to HIV is doubtful as many were enacted prior to the HIV epidemic and there have been no prosecutions for HIV exposure under such statutes. In the absence of specific HIV exposure laws, states have prosecuted incidents of HIV exposure under general criminal laws, including assault and reckless endangerment.

In *Brock v. State,*[17] an HIV-positive inmate who was in the AIDS unit of an Alabama prison was charged with attempted murder and two counts of assault when he allegedly became belligerent and bit a police officer. The police officer did not test positive for HIV. At trial, the jury acquitted Brock of the attempted murder charge but convicted him of first-degree assault, a crime which required that the defendant both intend to cause and actually cause "serious physical injury" with a "deadly

[15] ALA. ADMIN. CODE r. 420-4-1-.03(2008). Alabama law defines a person as acting "knowingly" when "he is aware that his conduct is of that nature of that the circumstance existed." ALA. CODE § 13A-2-2(1975).
[16] Other state statutes have criminal exposure statutes for "sexually transmitted diseases," "infectious venereal diseases," etc. *See e.g.* CAL. HEALTH & SAFETY CODE § 120600 (West 2010); LA. REV. STAT. ANN. § 40:1062 (2008); MONT. CODE ANN. § 50-18-112 (1989); N.Y. PUB. HEALTH LAW § 2307 (McKinney 2001); S.C. CODE ANN. § 44-29-60 (2009); TENN. CODE. ANN. § 68-10-107 (2010); VT. STAT. ANN. TIT. 18 § 1106 (1973); W. VA. CODE § 16-4-20 (2010). There has never been a prosecution for HIV exposure under any of these statutes. Prosecutions for HIV exposure, if any, have arisen out of the general criminal law or HIV-specific exposure statutes of these states.
[17] 555 So. 2d 285 (Ala. Crim. App. 1989).

weapon or dangerous instrument."[18] The prosecution argued that because the defendant was HIV-positive, his mouth and teeth were "highly capable of causing death or serious physical injury" and should be considered dangerous weapons or instruments for the purposes of the assault charges.

On appeal, Alabama's Court of Criminal Appeals dismissed the first-degree assault conviction and downgraded his conviction to assault in the third degree. The court held that the state failed to establish the essential elements of a case of first-degree assault against Brock. The court stated that no evidence was provided that Brock's mouth and teeth were "deadly weapon[s]" as defined by Alabama statute. Moreover, the state did not prove that Brock intended to cause serious physical harm to the prison guard. The court noted that the state provided no evidence that AIDS can be transmitted through a human bite, and that the court did not believe it to be an established scientific fact that AIDS could be transmitted in such a manner.

The CDC has concluded that there exists only a "remote" possibility that HIV could be transmitted through a bite and such transmission would have to involve various aggravating factors, including "severe trauma, extensive tissue damage, and the presence of blood."[19] The CDC has also maintained that saliva alone has never been shown to transmit HIV.[20] Despite these findings, there have still been prosecutions, and upheld convictions, for HIV exposure for biting or spitting. (*See* Texas).

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, it should not be used as a substitute for legal advice.

[18] ALA. CODE § 13A-6-20 (1987).
[19] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted through a human bite?* (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).
[20] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted by being spit on by an HIV-infected person?* (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).

Alaska Statute(s) that Allow for Criminal Prosecution Based on HIV Status:

ALASKA STAT. § 12.55.155(C)(33)
Sentence Enhancement for HIV Exposure

(c) The following factors shall be considered by the sentencing court if proven in accordance with this section, and may allow imposition of a sentence above the presumptive range set out in AS 12.55.125:

(33) the offense was a felony specified in AS 11.41.410 - 11.41.455, the defendant had been previously diagnosed as having or having tested positive for HIV or AIDS, and the offense either (A) involved penetration, or (B) exposed the victim to a risk or a fear that the offense could result in the transmission of HIV or AIDS; in this paragraph, "HIV" and "AIDS" have the meanings given in AS 18.15.310.

ALASKA STAT. § 11.41.410 - 11.41.455

ALASKA STAT. § 11.41.410 Sexual assault, first degree
Unclassified felony

ALASKA STAT. § 11.41.420 Sexual assault, second degree
Class B felony

ALASKA STAT. § 11.41.425 Sexual assault, third degree
Class C felony

ALASKA STAT. § 11.41.427 Sexual assault, fourth degree
Class A misdemeanor

ALASKA STAT. § 11.41.434 Sexual abuse of a minor, first degree Unclassified felony

ALASKA STAT. § 11.41.436 Sexual abuse of a minor, second degree
Class B felony

ALASKA STAT. § 11.41.438 Sexual abuse of a minor, third degree
Class C felony

ALASKA STAT. § 11.41.440 Sexual abuse of a minor, fourth degree
Class A misdemeanor

ALASKA STAT. § 11.41.450 Incest Class C felony

ALASKA STAT. § 11.41.452 Online enticement of a minor
Class C felony unless the defendant at the time of the offense was required to register as a sex offender or child kidnapper, in which case Class B felony

ALASKA STAT. § 11.41.455 Unlawful exploitation of a minor
Class B felony, unless the defendant has previously been convicted of this or a similar crime, in which case Class A felony

HIV-positive status may lead to higher prison sentences for felony sexual offenses.

Alaska has no statute explicitly criminalizing HIV transmission or exposure, but enhanced sentencing may be applicable based on a defendant's HIV status if she/he is found guilty of one of the specified sex offenses. If an HIV-positive person is found guilty of a sexually-based assault, she/he may receive an enhanced term of imprisonment if (1) the offense involved penetration or (2) the defendant exposed the victim to a risk or fear that HIV transmission could result. Neither the intent to transmit HIV nor actual transmission is required.

Alaska defines "sexual penetration" to include all intrusions "however slight, of an object or any part of a person's body into the genital or anal opening of another person's body."[21] An enhanced sentence can be imposed regardless of the defendant's viral load; whether protection, such as a condom, was used; or if the crime involved penetration with a body part or object that cannot transmit HIV.

In 1996, a man's HIV-positive status was considered an "aggravating factor," and he was sentenced to ten years for sexual abuse of a minor.[22] On appeal, the court affirmed the lower court's sentencing because the defendant knew he had HIV at the time of the sexual conduct with the minor, didn't disclose his status, and didn't take any measures to protect her from HIV. The court found that even though the minor provided a condom that was used for the second sexual encounter, and the minor had thus far tested negative for HIV, it was "safe to infer that [the minor] will be very fearful for some time to come" that she may test positive for HIV. The court determined that such considerations supported an enhanced sentence.

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, it should not be used as a substitute for legal advice.

[21] ALASKA STAT. § 11.81.900(59)(A) (2006).
[22] Wans v. State, No. A-6188, 1996 WL 671355 at * 1 (Alaska Ct. App. 1996).

Arizona Statute(s) that Allow for Criminal Prosecution Based on HIV Status:

No specific statute on record.

There are no explicit statutes regarding HIV or STI exposure.

There are no statutes explicitly criminalizing HIV transmission or exposure in Arizona. However, in some states, HIV-positive people have been prosecuted for HIV exposure under general criminal laws, such as reckless endangerment and aggravated assault.

At the time of this publication, the authors are not aware of a criminal prosecution of an individual on the basis of that person's HIV status in Arizona.

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Arkansas Statute(s) that Allow for Criminal Prosecution Based on HIV Status:

ARK. CODE ANN. § 5-14-123

Knowingly "Transmitting" AIDS, HIV

(a) A person with acquired immunodeficiency syndrome or who tests positive for the presence of human immunodeficiency virus antigen or antibodies is infectious to another person through the exchange of a body fluid during sexual intercourse and through the parenteral transfer of blood or a blood product and under these circumstances is a danger to the public.

(b) A person commits the offense of exposing another person to human immunodeficiency virus if the person knows he or she has tested positive for human immunodeficiency virus and exposes another person to human immunodeficiency virus infection through the parenteral transfer of blood or a blood product or engages in sexual penetration with another person without first having informed the other person of the presence of human immunodeficiency virus.

(c) (1) As used in this section, "sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into a genital or anal opening of another person's body.

(2) However, emission of semen is not required.

(d) Exposing another person to human immunodeficiency virus is a Class A felony.

ARK. CODE ANN. § 20-15-903

Receiving Health Care

A person who is HIV-positive must, prior to receiving any health care services of a physician or dentist, advise such physician or dentist that the person has HIV. Failure to do so is a Class A misdemeanor.

ARK. CODE ANN. § 5-4-401

Sentence

For a Class A felony, the sentence shall not be less than six years but not more than thirty years.

For a Class A misdemeanor, the sentence shall not exceed one year.

ARK. CODE ANN. § 5-4-201

Fines – Limitation on Amount

A defendant convicted of a felony may be ordered to pay a fine not exceeding $15,000 if the conviction is of a Class A or Class B felony.

A defendant convicted of a misdemeanor may be sentenced to pay a fine not exceeding $2,500 if the conviction is of a Class A misdemeanor.

To avoid the risk of arrest and prosecution, HIV status must be disclosed to partners before engaging in sexual activities.

People living with HIV in Arkansas should be aware that penalties for engaging in a broad range of sexual activities, without being able to prove that you first notified partners of one's HIV status, can result in criminal penalties. If a person in Arkansas is aware that she/he is HIV-positive, she/he must disclose this to a sexual partner before engaging in penile-vaginal sex, anal sex, oral sex, or the insertion of any body part of an HIV-positive person, or any object, into the genital or anal openings of another person.[23] Though the statute's title emphasizes "transmitting AIDS/HIV," neither the intent to transmit HIV, actual transmission of HIV, or the ejaculation of semen are required for prosecution.

The only affirmative defense to prosecution is the disclosure of one's HIV status. However, it is difficult to prove whether HIV status was disclosed in the course of private sexual activities because the evidence in these matters is often, if not always, limited to "he said, she said" testimony by the parties or third-party witnesses. In *State v. Weaver*, for example, an HIV-positive man was sentenced to a thirty-year imprisonment for allegedly having sex without disclosing his status, even though he maintained at trial that he did disclose his status to his partner.[24] To rebut the defendant's testimony, the prosecution called a health official to testify that the defendant said he would infect anyone he could if he was HIV-positive. On appeal, the court found that the rebuttal testimony was sufficient as it went to the intent of the defendant to expose others to HIV, and therefore to the fact that the defendant probably did not tell the complainant that he was HIV-positive.[25]

Prosecutions of HIV exposure cases raise serious issues as to the confidentiality of medical records and patient history. In criminalization matters, states often authorize the disclosure of otherwise confidential HIV information. Disclosure of this information does not require the defendant's authorization even though it is her/his confidential medical information that is being disseminated to third parties. In a second trial to prosecute the same defendant from *Weaver* on two additional counts of exposing another to HIV, the state obtained the defendant's medical records from the county health department by issuing an investigative subpoena, which did not require court approval.[26] The defendant was convicted of those remaining counts and sentenced to thirty years for each count, to be served concurrently with his prior conviction. On appeal, the defendant argued that the medical records were obtained in violation of the state's rule of criminal procedure, rules of evidence, as well as the state and federal constitutions. The Arkansas Court of Appeals found that the prosecutor's use of the investigative subpoena was proper because prosecutors are statutorily allowed to subpoena medical records without court approval if it is for the investigation of a crime.[27]

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[23] ARK. CODE ANN. § 5-14-123 (West 2010).
[24] 939 S.W.2d 316, 318 (Ark. Ct. App. 1997).
[25] *Id.* at 319.
[26] Weaver v. State, 990 S.W.2d 572 (Ark. Ct. App. 1999).
[27] *Id.* at 574-75, (citing ARK. CODE ANN. § 20-15-904(c)) ("(a) [A] person with Acquired Immunodeficiency Syndrome (AIDS) or who tests positive for the presence of Human Immunodeficiency Virus (HIV) antigen or antibodies is infectious to others through the exchange of body fluids during sexual intercourse and through the parenteral transfer of blood or blood products and under these circumstances is a danger to the public. (b) A physician whose patient is determined to have Acquired Immunodeficiency Syndrome (AIDS) or who tests positive for the presence of Human Immunodeficiency Virus (HIV) antigen or antibodies shall immediately make a report to the Arkansas Department of Health in such manner and form as the department shall direct. (c)(1) All information and reports in connection with persons suffering from or suspected to be suffering from the diseases specified in this section shall be regarded as confidential by any and every person, body, or committee whose duty it is or may be to obtain, make, transmit, and receive such information and reports. (2) *However, any prosecuting attorney of this state may subpoena such information as may be necessary to enforce the provisions of this section and 5-14-123 and 16-82-101, provided that any information acquired pursuant to such subpoena shall not be disclosed except to the courts to enforce the provisions of this section."* (Emphasis added)).

Arkansas also requires court-ordered involuntary HIV testing for complainant notification. All criminal defendants in Arkansas charged with sexual assault, incest, or prostitution may be required to submit to an HIV test and, upon conviction, and at the victim's request, will be required to take an HIV test.[28] At least thirty-three states have passed similar statutes permitting involuntary HIV testing of certain suspects, defendants, or convicts.[29]

Sentences for violating Arkansas's HIV exposure statute are severe. The minimum sentence for the Class A felony is six years, but sentences and fines of up to thirty years and $15,000 are possible.[30] Sex offender registration may also be required by a sentencing court,[31] which often leads to community ostracism and serious problems finding employment. The following cases serve as illustrations of possible penalties for violating Arkansas' criminal exposure statute:

- An HIV-positive man was sentenced to twenty years imprisonment in March 2010 after engaging in unprotected sex with a woman without first disclosing his status.[32]
- In May 2009, a 17-year-old high school student was arrested for failing to inform his teenage sexual partner of his HIV status before engaging in unprotected sex. He was charged as an adult and sentenced to fifteen years in jail after pleading guilty to five counts of exposing another person to HIV. Part of his sentence included mandatory sex offender registration.[33]
- In May 2008, a 33-year-old, HIV-positive man was sentenced to twelve years in prison for failing to disclose his HIV status to his girlfriend and another woman prior to engaging in sexual conduct. The man also had to register as a sex offender. Neither of the women tested positive for HIV.[34]

Exposing another to HIV-positive blood is criminally punishable.

Because the law punishes "parenteral" exposure—i.e., exposure through a break in the skin or through a mucus membrane—prosecutions are possible if any amount of HIV-positive blood makes contact with another individual's non-intact skin, eyes, nose, mouth, or other area involving a mucus membrane. In May 2010, a 41-year-old, HIV-positive man was charged with criminal exposure to HIV after allegedly

[28] ARK. CODE ANN. § 16-82-101(2003).
[29] ALA. CODE § 22-11A-17 (2010); ARIZ. REV. STAT. ANN. § 13-1415 (2010); CAL. PENAL CODE §§ 1202.1, 1202.6 (West 2004); CAL. HEALTH & SAFETY CODE §§ 121050, 121055 (West 2006); COLO. REV. STAT. §§ 18-3-415, 18-7-205.5 (West 2004); CONN. GEN. STAT. §§ 54-102a, 102b (2010); FLA. STAT. ANN. §§ 775.0877, 796.08 (West 2010); GA. CODE ANN. § 17-10-15 (West 2010); 730 ILL COMP. STAT. ANN. § 5/5-5-3 (West 2010); IND. CODE ANN. § 35-38-1-10.5 (West 2010); KY. REV. STAT. ANN. §§ 510.320, 510.090 (West 2010); LA. REV. STAT. ANN. § 15:535 (2005); LA. CODE CRIM. PROC. ANN. art. 499 (2003); ME. REV. STAT. ANN. tit. 5, §§ 19203-A, 19203-F (2002); MICH. COMP. LAWS. ANN. § 333.5129 (West 2001); MISS. CODE ANN. §§ 99-19-201, 99-19-203, 43-21-623 (West 2010); MO. ANN. STAT. § 191.663 (West 2004); MONT. CODE ANN. § 46-18-256 (2010); NEB. REV. STAT. § 29-2290 (2010); NEV. REV. STAT. §§ 201.356, 441A.320 (2009); N.H. REV. STAT. ANN. §§ 632-A:10-b (2010); N.J. REV. STAT. §§ 2A:4A-43.1, 2C:43-2.2 (2005); N.M. STAT. ANN. §24-2B-5.1 (2010); N.Y. CODE CRIM. PROC. § 390.15 (McKinney 2005); N.Y. FAM. CT. ACT § 347.1 (McKinney 2008); N.D. CENT. CODE § 23-07-07.5 (2010); OHIO REV. CODE ANN. § 2907.27 (West 2010); OKLA. STAT. ANN. tit. 63, §§ 1-524, 525 (West 2005); OR. REV. STAT. § 135.139 (2003); 35 PA. CONS. STAT. ANN. §§ 521.11a, 7608 (West 2003); TENN. CODE ANN. §§ 39-13-521, 68-10-116 (West 2010); TEX. CODE CRIM. PROC. ANN. art. 21.31 (Vernon 2009); VA. CODE ANN. §§ 18.2-62, 18.2-346.1 (West 2010); WASH. REV. CODE ANN. §§ 70.24.330, 70.24.105 (West 2002); W. VA. CODE §§ 16-3C-2(f), 16-3C-3-5 (2010); WIS. STAT. §§ 252.15, 968.38 (2010).
[30] ARK. CODE ANN. § 5-4-401(a)(2) (West 2010); § 5-4-201(a)(1).
[31] § 12-12-903 (12)(A)(i)(P).
[32] Wanda Freeman, *HIV-positive Man Gets 20-year Term*, TIMES REC. ONLINE, Mar. 11, 2010, http://www.swtimes.com/news/article_65cead58-2a9f-51f9-b9be-3fd6c779af14.html.
[33] *Local Teen Charged with Spreading HIV Virus*, 4029TV.COM, May 19, 2009, http://www.4029tv.com/news/19507766/detail.html; Tracy Neal, *Grey Sentenced to 15 Years*, NWAONLINE.COM, Dec. 22, 2009, http://www.nwaonline.com/news/2009/dec/22/gray-sentenced-15-years/.
[34] Ron Wood, *Man Gets Prison Term for Exposing Woman to HIV*, MORNING NEWS, May 2, 2008 http://criminalhivtransmission.blogspot.com/2008/05/33-year-old-arkansas-man-who-pleaded.html.

spitting blood at a police officer. [35]

HIV status must be disclosed before receiving medical treatment.

All people in Arkansas who are aware that they are HIV-positive must inform doctors or dentists of their HIV status before receiving treatment.[36] Failure to meet this requirement is punishable by up to one year in prison, a $2,500 fine, or both.

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[35] Gavin Lesnick, *HIV-positive Man Spits Blood at Police Officer, Report Says*, ARKANSASONLINE.COM, May 12, 2010, http://www.arkansasonline.com/news/2010/may/12/hiv-positive-man-spits-blood-officer-report-says/?latest.
[36] ARK. CODE ANN. § 20-15-903.

California Statute(s) that Allow for Criminal Prosecution Based on HIV Status:

CAL. HEALTH & SAFETY CODE § 120291

Unprotected sexual activity by one who knows self to be infected by HIV

Any person who exposes another to HIV by engaging in unprotected sexual activity (anal or vaginal intercourse without a condom) when the infected person knows at the time of the unprotected sex that she/he is infected with HIV, has not disclosed her/his HIV-positive status, and acts with the specific intent to infect the other person with HIV, is guilty of a felony punishable by three, five, or eight years imprisonment. A person's knowledge of her/his HIV-positive status, without additional evidence, is not sufficient to prove specific intent.

CAL. HEALTH AND SAFETY CODE § 120290

Willful exposure of self or others to disease

Except as provided in Section 120291 above, or in the case of the removal of an afflicted person in a manner the least dangerous to the public health, any person afflicted with any contagious, infectious, or communicable disease who willfully exposes herself/himself to another person, and any person who willfully exposes another person afflicted with the disease to someone else, is guilty of a misdemeanor.

CAL. PENAL CODE § 12022.85

Sentence enhancement for sexual offenses

Any person who commits rape, unlawful intercourse with a female under the age of eighteen, spousal rape, sodomy, or oral copulation with the knowledge that she/he is infected with HIV at the time of commission, shall receive a three-year enhancement for each violation in addition to the sentence provided for the sexual offense itself.

CAL. HEALTH AND SAFETY CODE § 1621.5

Donation of blood, etc., by person know that he or she has HIV/AIDS

It is a felony punishable by imprisonment in the state prison for two, four, or six years, for any person who knows that she/he has HIV/AIDS to donate blood, body organs or other tissue, semen to any medical center or semen bank that receives semen for purposes of artificial insemination, or breast milk to any medical center or breast milk bank that receives breast milk for purposes of distribution, whether she/he is a paid or a volunteer donor. This measure does not apply to any person who (1) is mentally incompetent, (2) self-defers her/his blood (indicates that it should not be used for transfusion, but only for research purposes), or (3) donates her/his blood for purposes of an autologous donation—i.e., donates for use in another part of the donor's body.

CAL. PENAL CODE § 647F

Penalty enhancements concerning prostitution

If a defendant charged with prostitution or soliciting prostitution has been previously convicted one or more times of that misdemeanor crime, or of any other sexual offense, and in connection with one or more of those convictions a blood test for HIV was administered with positive test results, of which the defendant was informed, the defendant is guilty of a felony.

Punishment for violation of this statute can range from sixteen months to three years or imprisonment in the county jail not to exceed one year and/or a fine. CAL. PENAL CODE § 18.

HIV-positive persons may be prosecuted for engaging in unprotected sexual intercourse with the specific intent to transmit HIV.

Under California's felony exposure statute, imprisonment for three, five, or eight years may follow if an HIV-positive person (1) engages in unprotected penile-vaginal sex or unprotected anal sex, (2) with knowledge of her/his positive status, (3) without disclosing HIV status to sexual partners, *and* (4) with the specific intent to transmit HIV.[37] No actual transmission of the virus is required.

Proof of disclosure of one's status and/or using condoms, or other protection, are affirmative defenses to prosecution. Importantly, an HIV-positive person will only be prosecuted if there is proof that the person *specifically intended* to transmit HIV to a partner. Knowledge of one's HIV

[37] CAL. HEALTH & SAFETY CODE § 120291 (West 2010).

status alone is insufficient for prosecution. In other jurisdictions intent has been shown through statements a defendant made about wanting to infect others with HIV.[38]

In September 2010, a 41-year-old man pleaded guilty to having unprotected sexual activity while knowing he was HIV-positive and acting with the intent to infect his sexual partner.[39] This is the only case on record of anyone ever being charged or convicted under California's statute.

HIV-positive individuals may receive enhanced sentences or aggravated assault charges for sex crimes.

California imposes sentence enhancements for sex offenders who are HIV-positive. Specifically, if a person living with HIV/AIDS knows her/his status and commits a sex offense, or multiple sex offenses, an additional three years in prison are required for each offense.[40]

No intent to transmit HIV or actual transmission is required.

The sentencing law may be applied regardless of the defendant's viral load, whether condoms or other protection were used, or whether HIV could have been transmitted during the acts in question.

Although cases arising under sentence enhancement laws are rare in California, in 1998 a man received a sentence enhancement of nine additional years in prison for having unprotected sex with a minor while being HIV-positive.[41] On a challenge to the sentencing enhancement statute, the California Court of Appeal declined to label the application of the statute "cruel and unusual punishment" under the Eighth Amendment, as it did not punish HIV-positive status but punished conduct.[42]

Sexual assault charges may also be elevated to aggravated assault charges if the HIV-positive defendant fails to use protection. In *Roman v. Superior Court*,[43] an HIV-positive man anally raped a minor without using a condom, and the court found that to be sufficient evidence that the defendant engaged in conduct "likely to produce great bodily harm or death," elevating his charge to aggravated assault from sexual assault. No actual finding of HIV transmission was required.

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[38] *See* State v. Stark, 832 P.2d 109 (Wash. Ct. App. 1992)(finding that HIV-positive defendant's statement, "I don't care. If I'm going to die, everybody's going to die," when talking about his sexual activity, was sufficient to show intent to inflict bodily injury on his sexual partners through exposure to HIV); Commonwealth v. Walker, 836 A.2d 999 (Pa. Super. Ct. 1999)(an HIV-positive man was found guilty of communicating terrorist threats when he scratched a parole officer on the hand and said, "I have open cuts on my hands. Life is short. I am taking you with me." The court found that the statement was sufficient to show intent.

[39] Tomoya Shimura, *Gang Member Pleads Guilty to Spreading HIV*, HIGHDESERT.COM, Sept. 7, 2010, available at http://www.highdesert.com/articles/spreading-21626-vvdailypress-gang-victorville.html]

[40] CAL. PENAL CODE § 12022.85 (West 2010).

[41] Guevara v. Superior Court, 73 Cal. Rptr. 2d 421 (Cal. Ct. App. 1998).

[42] *Id.* at 425; (distinguishing *Robinson v. California*, 370 U.S. 660 (1962) and finding a statute punishing the status of being addicted to drugs while in California void as cruel and unusual punishment).

[43] 5 Cal. Rptr. 3d 807 (Cal. Ct. App. 2003).

Heightened penalties may result from activities as a sex worker or soliciting sex while HIV-positive.[44]

California prostitution laws provide for additional penalties when an HIV-positive individual is found guilty of either engaging in or soliciting prostitution. Under § 647F of the California Penal Code, if an individual is (1) found guilty of either soliciting or engaging in prostitution, (2) has previously been convicted of a sex offense, and (3) tested positive for HIV following a previous sex offense conviction, she/he is guilty of a felony and may be imprisoned for up to three years.[45]

This sentencing law punishes a defendant for being HIV-positive regardless of whether she/he intended to transmit HIV, transmitted the virus, or engaged in activities likely or possible to do so. To commit a felony under this statute, no actual sexual activity is required. A conviction for prostitution is possible as long as a defendant does some act proving an intent and agreement to engage in prostitution.[46]

In 2007, an HIV-positive sex worker was charged with exposing others to HIV and felony prostitution.[47] She had previously been convicted of prostitution and had tested positive for HIV.[48] The defendant had condoms in her possession and had not yet engaged in sex with an undercover officer. On appeal, the court upheld the felony prostitution charge but dismissed the exposure charge finding that there was not a specific intent to transmit HIV.

Individuals with HIV must not donate blood, organs and other tissues, semen, or breast milk, to others.[49]

A person may face two, four, or six years imprisonment if she/he is aware of her/his HIV-positive status and donates blood, body organs or tissues, semen, or breast milk. No intent to transmit HIV or actual transmission of the virus is required. An individual will not be prosecuted under the following circumstances:

- She/he is mentally incompetent;
- Blood is donated and official procedures for "self-deferring" their blood[50] (indicating that blood should only be used for science purposes, and not for transfusion);
- Donate blood for autologous use (use in another part of the donor's own body).

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[44] Prior to California's statutes on HIV exposure and HIV-specific statute enhancements, there were a few cases where persons who knew they were HIV-positive and solicited or engaged in prostitution faced penalties under general criminal laws. In 1987, an HIV-positive sex worker was charged with attempted murder and her pimp was charged with pimping and willfully exposing another to a contagious disease. However, the charges were later dropped when a witness refused to testify. *Main News: The State*, LOS ANGELES TIMES, July 24, 1987, at 2.

[45] See above discussion of California sentencing laws for a list of sex offenses covered under this statute; *See also* CAL. PENAL CODE § 647F (West 2010); CAL. PENAL CODE § 18 (West 2010).

[46] CAL. PENAL CODE § 647(B) (2010).

[47] People v. Hall, No. B190199, 2007 WL 2121912 (Cal. Ct. App. July 25, 2007).

[48] *Id.*

[49] Prior to California's HIV-specific statute on blood and organ donations, an HIV-positive homeless man was acquitted on charges of attempting to poison a pharmaceutical product after selling his blood. Terry Pristin, *Jury Frees AIDS Victim Who Sold Infected Blood*, LOS ANGELES TIMES, March 3, 1998, at 1.

[50] *See* CAL. HEALTH & SAFETY CODE § 1603.3(B) (West 2010).

HIV-positive persons have also been convicted under general criminal charges.[51]

In *Beuford v. People*, the California Court of Appeals confirmed a conviction for, amongst other charges, making criminal threats.[52] The defendant was resisting arrest and, while spitting at the officers, made comments including, "I'll make your life miserable because I'm infected with HIV." A criminal threat under California law is a threat that is intended to and does cause fear in the person threatened.[53] The State must prove that (1) the defendant threatened to kill or inflict bodily injury on another person, (2) intended the threat to be understood as such, (3) communicated the serious intention that the threat would be carried out, (4) the threat caused the person to be in fear and (5) such fear was reasonable. The court held that the language and actions of the defendant could reasonably be found to be criminal threats by a jury.

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[51] In a 1987 case, the defendant successfully sued the San Diego Police Department for taking and testing his blood for HIV without consent or by warrant after he bit the officers. Barlow v. County of San Diego, 190 Cal. App. 3d 1652 (Cal. Ct. App. 1987). He was originally charged with intent to kill and inflict great bodily harm on the officers. A jury later acquitted him of all criminal charges. Barlow v. Ground, 943 F.2d 1132 (9th Cir. 1991)

[52] No. B196860, 2008 WL 5091389 (Cal. Ct. App. Dec. 4, 2008).

[53] CAL. PENAL CODE § 422 (West 2010).

Colorado Statute(s) that Allow for Criminal Prosecution based on HIV Status:

COLO. REV. STAT. § 18-3-415.5

Sentence enhancement

If it is proven beyond a reasonable doubt that a person had notice of his or her HIV infection prior to the date that he or she committed a sexual offense, the judge shall sentence the person to a mandatory term of incarceration of at least three times the upper limit of the presumptive range for the level of offense committed, up to the remainder of the person's life. "Sexual offense" refers to sexual offenses consisting of sexual penetration as defined in COLO. REV. STAT. § 18-3-401(6). *See also* COLO. REV. STAT. § 18-1.3-1004.

COLO. REV. STAT. § 18-7-201.7

Prostitution with knowledge of being HIV-positive

Any person who, in exchange for money or any other thing of value, performs or offers or agrees to perform, with any person not her/his spouse, any act of sexual intercourse, oral sex, masturbation or anal intercourse and does so with knowledge of having tested positive for HIV, is guilty of a Class 5 felony.

COLO. REV. STAT. § 18-7-205.7

Patronizing a prostitute

Any person with knowledge of being infected with HIV who patronizes a prostitute is guilty of a Class 6 felony. ("Patronizing a prostitute" is defined in Colo. Rev. Stat. § 18-7-205). This law does not apply to spouses.

COLO. REV. STAT. § 18-1.3-401

Felonies classified – presumptive penalties

Class 5 felony sentence: minimum one-year imprisonment, maximum three years imprisonment.

Class 6 felony sentence: minimum one-year imprisonment, maximum eighteen months imprisonment.

The prison sentences of HIV-positive persons convicted of sex offenses may be severely increased due to HIV status.

Individuals living with HIV in Colorado should be aware that they may receive prison sentences dramatically above those of HIV-negative persons if they are convicted of a sex offense, including rape and sexual assault, regardless of whether their alleged conduct exposed others to a significant risk of HIV transmission or if they had the intent to expose others to HIV. Specifically, if an HIV-positive person is convicted of a sexual offense involving penetration and aware that she/he is HIV-positive, a sentencing judge is required to impose a sentence of at least three times the upper limit of the normal sentencing range which could extend to the remainder of a person's natural life.[54] "Penetration" is defined as penile-vaginal sex, oral sex, oral stimulation of the anus, or anal sex.[55] Even under the most lenient application of this statute, penalties for sexual assault would be elevated from six to eighteen years.[56]

The use of protection during a sexual offense is not a defense, no ejaculation or emission of bodily fluid is required, and any degree of penetration, however slight, is sufficient to support the imposition of an increased sentence.[57] The actual likelihood of HIV transmission during a sexual assault is not a consideration. Neither the intent to transmit HIV nor actual transmission is required.

HIV exposure cases have been prosecuted under general criminal laws in Colorado.

Incidents of HIV exposure in Colorado have been prosecuted under a variety of general criminal laws, including reckless endangerment statutes, regardless of the actual likelihood of transmission. In a 1999 case, an HIV-positive man was charged with attempted manslaughter when, knowing his HIV status, he did not use a condom during anal sex with a twelve-year old boy.[58] The man was eventually convicted of two counts of sexual assault and reckless endangerment, an originally lesser included offense for an attempted murder charge, for failing to use a condom during the sexual encounter, even though he knew he was HIV-positive.[59] Reckless endangerment is defined as exposing another to a "substantial risk of serious bodily injury"[60] and a conscious disregard of a substantial and unjustifiable risk. Reckless endangerment statutes do not require proof of purpose or intent to transmit HIV, nor does it matter if HIV is actually transmitted, as long as there was a "risk" of transmission.

Felony menacing charges may also apply if an HIV-positive person attempts to or succeeds in placing another in fear of "imminent serious bodily injury."[61] Menacing is defined as a person knowingly, by threat or physical action, placing another in fear of imminent serious bodily injury and

[54] COLO. REV. STAT. § 18-3-415.5 (2004).
[55] § 18-3-401 (2004).
[56] § 18-1.3-401(1)(V)(A) (2) (2004).
[57] *Id.*
[58] People v. Dembry, 91 P.3d 431, 433 (Colo. Ct. App. 2003); Erin Emery, *Sex-assault Suspect Worked as Counselor*, DENVER POST, Feb. 20, 1999, at B-01.
[59] *Dembry*, 91 P.3d at 433.
[60] COLO. REV. STAT. § 18-3-208 (2004).
[61] § 18-3-206.

is a Class 5 felony if it is committed by a deadly weapon or by representing that the person is armed with a deadly weapon.[62] In *People v. Shawn,* the Colorado Court of Appeals held that a person's HIV-positive status could be a deadly weapon for the purposes of the menacing statute because HIV is capable of causing significant injury.[63] In that case, an HIV-positive man was convicted of menacing when he allegedly scratched and pinched a store manager, broke his skin, and shouted "I'm HIV-positive, let go of me, let go of me." Despite the fact that the store manager was not placed in fear of serious bodily injury, the court concluded that the defendant's statements were intended to cause such fear and, as such, were menacing. The court also determined that HIV was a deadly weapon, because a deadly weapon does not have to be *likely* to cause serious bodily injury, only *capable* of doing so.[64] The court determined that "the dangers of HIV are widely known," and the man's HIV status was "used" as a weapon when he broke the store manager's skin, giving himself "ready access to means of transmitting HIV."[65]

In *People v. Perez*, an HIV-positive man in Colorado was convicted of attempted extreme indifference murder[66] and two counts of sexual abuse when he allegedly made his step-daughter engage in masturbation, oral sex, and penile-vaginal sex while knowing that he was HIV-positive.[67] On appeal, the defendant argued that he did not act with the "universal malice" necessary for the attempted murder conviction. The crime of extreme indifference murder (now known as murder is the first degree) requires that, with an attitude of universal malice manifesting in extreme indifference to the value of human life, the defendant knowingly engages in conduct which creates a great risk of death to another person, and thereby causes the death of another.[68] "Universal malice" is defined as the "depravity of the human heart which determines to take life upon slight or insufficient provocation, without knowing or caring who may be the victim," and is aimed at conduct that places the lives of many people in danger without focusing on any one person's life in particular.[69] On appeal the Colorado Court of Appeals found that there was not sufficient evidence to show that there was any universal malice because the defendant knew the victim, and his conduct was directed towards her and her alone, as opposed to other unknown victims. On this basis, the attempted murder conviction was overturned.

Other cases of HIV exposure being prosecuted under general criminal laws in Colorado include:

- In 2009, an HIV-positive man pleaded guilty to felony child abuse and was sentenced to fifteen years imprisonment after he failed to tell his pregnant fiancée that he was HIV-positive.[70] His fiancée and son tested positive for HIV after

[62] *Id.*
[63] 107 P.3d 1033, 1036 (Colo. App. 2004).
[64] *Id.* at 1036
[65] *Id.* at 1037
[66] The crime has since been renamed "murder in the first degree." COLO. REV. STAT. § 18-3-102 (2004).
[67] 972 P.2d 1072, 1073 (Colo. App. 1998).
[68] COLO. REV. STAT. § 18-3-102(d) (2004).
[69] *Perez*, 107 P.3d at 1074, (citing Longinotti v. People, 102 P. 165, 168 (Colo. 1909)).
[70] *Man Gets 15 Years for Infecting Son with HIV,* CBS4DENVER.COM, July 18, 2009, http://cbs4denver.com/crime/prison.sentence.infecting.2.1091727.html.

doctors were puzzled why the four-month-old baby wasn't gaining weight and had pneumonia.[71]

- In June 2010, an HIV-positive man was charged with assault with a "deadly weapon" after he allegedly spat on a technician while being fitted for an electronic monitoring bracelet. His charge was later reduced to misdemeanor harassment.[72]

It is a felony to solicit prostitution while HIV-positive.

Individuals living with HIV/AIDS in Colorado will face felony charges for engaging in prostitution with knowledge of their HIV-positive status. It is a Class 6 felony punishable by up to eighteen months in prison and/or a $1,000 fine to "patronize" a prostitute after testing positive for HIV.[73] "Patronizing" a prostitute is defined as (1) engaging in sexual or "deviate sexual conduct" with a prostitute, or (2) entering or remaining in a "place of prostitution" with intent to engage in such acts.

Although the meaning of "deviate sexual conduct" is not defined, Colorado defines "sexual intercourse" for the purposes of prostitution as penile-vaginal sex, oral sex, masturbation, and anal sex in exchange for money or things of value.[74]

It is a felony to engage in prostitution while HIV-positive.

It is a Class 5 felony punishable by up to three years in prison and/or a $1,000 fine for a person who is aware of her/his HIV-positive status to perform, offer to perform, or agree to perform any act of penile-vaginal sex, oral sex, masturbation, or anal sex in exchange for money or any other thing of value.[75]

In July 2007, an HIV-positive sex worker in Denver was arrested after a police officer saw him offering to perform sexual acts for money. The man was charged with engaging in prostitution with knowledge that he was HIV-positive[76] and received an eighteen-month prison sentence after pleading guilty to attempted prostitution. Following another arrest in November 2009, he was once again charged for prostitution with knowledge of being HIV-positive.[77]

The solicitation and prostitution statutes punish individuals for being HIV-positive, regardless of whether or not they exposed another to a significant risk of HIV transmission. Because intent to engage in prostitution is punishable, an HIV-positive person may be imprisoned regardless of whether there was any sexual conduct that could have resulted in HIV transmission or if one's HIV

[71] Jessica Zartler, *HIV Positive Man Charged with Child Abuse*, NBC11NEWS.COM, Jan. 6, 2009, http://www.nbc11news.com/home/headlines/37152584.html.
[72] Joseph Boven, *Denver HIV-positive Man Charged With Using Spit as a Deadly Weapon*, COLORADO INDEPENDENT, June 9, 2010, http://coloradoindependent.com/55114/denver-hiv-positive-man-charged-with-using-spit-as-deadly-weapon; Felisa Cardona, *DA Drops Felony in Alleged Spitting*, DENVER POST, June 12, 2010, at B-03.
[73] COLO. REV. STAT. § 18-7-205.7 (2004); § 18-1.3-401(v)(a).
[74] § 18-7-201.
[75] § 18-7-201.7.
[76] Manny Gonzales, *Hooker Tells Cop at Arrest He Has AIDS*, DENVER POST, July 18, 2007, at B-05.
[77] *HIV-Positive Man Charged with Prostitution*, THE DENVER CHANNEL, Nov. 10, 2009, http://www.thedenverchannel.com/news/21577633/detail.html.

status would have been disclosed to the sexual partner. Neither the intent to transmit HIV or actual HIV transmission are required and using condoms or other protection is not a defense.

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, it should not be used as a substitute for legal advice.

Connecticut Statute(s) that Allow for Criminal Prosecution based on HIV Status:

No specific statute on record.

No explicit statutes regarding HIV exposure

There are no statutes explicitly criminalizing HIV transmission or exposure in Connecticut. However, in some states, HIV-positive people have been prosecuted for HIV exposure under general criminal laws, such as reckless endangerment and aggravated assault.

At the time of this publication, the authors are not aware of a criminal prosecution of an individual on the basis of that person's HIV status in Connecticut.

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, it should not be used as a substitute for legal advice.

Delaware Statute(s) that Allow for Criminal Prosecution based on HIV Status:

DEL. CODE ANN. tit. 16, § 2801(B)-(C)
Donating

(b) All donors of semen for purposes of artificial insemination, or donors of corneas, bones, organs or other human tissue for the purpose of injecting, transfusing or transplanting any of them in the human body, shall be tested for evidence of exposure to human immunodeficiency virus (HIV) and any other identified causative agent of Acquired Immunodeficiency Syndrome (AIDS) at the time of or after the donation, but prior to the semen, corneas, bones, organs or other human tissue being made available for such use. However, when in the opinion of the attending physician the life of a recipient of a bone, organ or other human tissue donation would be jeopardized by delays caused by testing for evidence for exposure to HIV and any other causative agent of AIDS, testing shall not be required prior to the life-saving measures.

(c) No person may intentionally, knowingly, recklessly or negligently use the semen, corneas, bones, organs or other human tissue of a donor unless the requirements of subsection (b) of this section have been met. No person may knowingly, recklessly or intentionally use the semen, corneas, bones, organs or other human tissue of a donor who has tested positive for exposure to HIV or any other identified causative agent of AIDS. Violation of this subsection shall be a class E felony.

There is no explicit statute criminalizing HIV exposure except for donations

There are no statutes explicitly criminalizing HIV transmission or exposure in Delaware other than in the context of organ, tissue, or semen donations. Under Delaware public health laws, it is a felony to fail to test for HIV or to knowingly, recklessly, or intentionally use the semen, corneas, bones, organs, or other human tissues donations of a person who has tested positive for HIV.[78] Violation of this statute is punishable by up to five years in prison. Sperm and tissue banks must follow state regulations for the testing and disposal of tissue donations found to be positive for HIV.[79]

Though Delaware does not have other HIV criminal exposure statutes, HIV-positive people have been prosecuted for HIV exposure under general criminal laws, such as reckless endangerment and aggravated assault in other states. At the time of this publication, the authors are not aware of a criminal prosecution of an individual on the basis of a person's HIV status in Delaware.

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, it should not be

[78] DEL. CODE ANN. tit. 16, § 2801(C) (2010); DEL CODE ANN. tit. 11, § 4205.
[79] *See generally id.* 16, § 2801.

used as a substitute for legal advice.

District of Columbia Statute(s) that Allow for Criminal Prosecution based on HIV Status:

No specific statute on record.

No explicit statutes criminalizing HIV exposure

There are no statutes explicitly criminalizing HIV transmission or exposure in the District of Columbia, and as of the date of publication the authors are not aware of any cases of prosecutions or sentence enhancements of individuals in the District of Columbia based on the HIV status of a defendant.

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, it should not be used as a substitute for legal advice.

Florida Statute(s) that Allow for Criminal Prosecution based on HIV Status:

FLA. STAT. ANN. § 384.24(2)

Unlawful acts relating to HIV exposure

It is unlawful for any person who has HIV, with knowledge of such infection and having been informed that she/he may communicate it to others through sexual intercourse, to have sexual intercourse with any other person, unless the other person has been informed of the presence of HIV and has consented to the sexual intercourse.

FLA. STAT. ANN. §384.34(5)

Penalties

Any person who violates the provisions of s. 384.24(2) commits a felony of the third degree, punishable as provided in ss. 775.082, 775.083, 775.084, and 775.0877(7). Any person who commits multiple violations of the provisions of s. 384.24(2) commits a felony of the first degree, punishable as provided in ss. 775.082, 775.083, 775.084, and 775.0877(7).

FLA. STAT. ANN. §381.0041(11)(B)

Donation or transfer of human tissue

Any person who knows she/he has HIV and has been informed that by donating blood, organs, or human tissues he or she may communicate HIV to another person, and with this knowledge donates blood, organs, plasma, skin, or human tissue is guilty of a felony of the third degree.

FLA. STAT. ANN. § 796.08(5)

Prostitution with knowledge of HIV-positive status

A person who commits prostitution, offers to commit prostitution or (by engaging in sexual activity likely to transmit HIV) procures another for prostitution, and who had previously tested positive for HIV and knew or had been informed of the test result and of the possibility of transmission to others through sexual activity is guilty of a third-degree felony.

FLA. STAT. ANN. § 775.0877

Criminal "transmission" of HIV (repeat offenses)

A person who pleads guilty or nolo contendere to, or is convicted of, committing or attempting to commit one of the crimes that is listed in subsection (1) of this statute

Continued on the next page…

HIV-positive persons may face felony charges for failing to disclose their status to sexual partners.

…*Continued from previous page*

[pertaining to sex or assault/battery offenses] and involves the transmission of bodily fluids from one person to another, who subsequently tested positive for HIV and was informed of that test result, and who then again commits one of the crimes listed in subsection (1) is guilty of criminal transmission of HIV, a felony of the third degree. The offenses listed in subsection (1) include, among others, sexual assault, incest, child abuse, indecent assault upon a minor child, sexual performance by a minor, donation of contaminated blood, assault, and battery.

FLA. STAT. ANN. § 775.082

Penalties: third-degree felony

Conviction of a felony of the third degree can result in a sentence of imprisonment not exceeding five years.

Penalties: second-degree felony

Conviction of a felony of the second degree can result in a sentence of imprisonment not exceeding 15 years.

Penalties: first-degree felony

Conviction of a felony of the first degree can result in a sentence of imprisonment not exceeding 30 years.

FLA. STAT. ANN. § 775.083

Fines

A person convicted of an offense other than capital felony may be sentenced to pay a fine, in addition to any punishment described in s. 775.082; Fines for designated crimes and for noncriminal violations shall not exceed $5,000 when the conviction of a felony is for the third degree.

In Florida, one may be prosecuted for failing to disclose HIV status to sexual partners. It is a third-degree felony, punishable by up to five years in prison and/or a $5,000 fine,[80] if an HIV-positive person (1) knows that she/he is HIV-positive, (2) has been informed that HIV may be transmitted during sexual intercourse,[81] and (3) has sexual intercourse with any other person without disclosing her/his HIV status.[82] It is a first-degree felony punishable by up to thirty years imprisonment if there is a failure to disclose one's HIV status on multiple occasions.[83]

Florida's statute penalizes conduct where HIV-positive persons know their status and engage in sexual conduct, currently limited to penile-vaginal sex, which may expose others to HIV. It is an affirmative defense if a sexual partner knows of her/his sexual partner's HIV status and consents to engage in sexual

[80] FLA. STAT. ANN. §§ 775.082-775.083 (West 2010).

[81] "Sexual intercourse" is defined as the "penetration of the female sex organ by the male sex organ, however slight, emission of semen is not required. § 826.04 (statute on Incest). While Florida's HIV exposure statute has also been applied to sexual intercourse between two men, two decisions in the summer of 2011 applied the statute as written and found that "sexual intercourse", and therefore the statute, did not apply to sex between two women or sex between two men. There is no statutory indication that oral sex is considered "sexual intercourse."

[82] § 384.24(2).

[83] § 384.34(5)("any person who commits multiple violations of s. 384.23(2) commits a felony of the first degree"); *See also* §§ 775.082-775.083.

conduct with that knowledge.[84] It is not a defense to prosecution if protection, such as a condom, was used during sex. Neither the intent to transmit HIV nor HIV transmission is required for prosecution.

The following cases illustrate prosecutions under this statute:

- In February 2010, a 45-year-old, HIV-positive man was charged with a first-degree felony of unlawful acts related to HIV exposure after allegedly failing to tell his sexual partner that he was HIV-positive during their long-term, romantic, sexual relationship.[85]
- In August 2009, a 39-year-old, HIV-positive woman was arrested after she allegedly had unprotected sex with a man and lied about her HIV status.[86]
- In July 2010, a 39-year old, HIV-positive man was arrested after he allegedly had unprotected sex with a woman without disclosing his HIV status.[87] The man's partner tested positive for HIV.

Donation of blood, organs, or other human tissues to others is a third-degree felony.

HIV-positive persons in Florida should be aware that they may receive up to five years in prison and/or a $5,000 fine[88] if they know their HIV-positive status and donate their blood, plasma, organs, skin, or human tissues.[89] It is a defense if the HIV-positive person has not been informed that HIV can be transmitted through human blood, plasma, organ, and tissue donations. Neither the intent to transmit HIV nor actual transmission of the virus is required.

Engaging in prostitution with knowledge of one's HIV-positive status is a felony.

Up to five years imprisonment and/or a $5,000 fine[90] can be imposed upon conviction if an individual (1) has tested positive for HIV, (2) been informed that HIV can be transmitted through sexual activity, and (3) commits prostitution, offers to commit prostitution, or procures another for prostitution by engaging in sexual activity in a manner likely to transmit HIV.[91]

Neither the intent to transmit HIV, actual transmission, or engaging in activities known to transmit HIV are required for prosecution.

Florida defines "prostitution" as the "giving or receiving of the body for sexual activity for hire." Much of what Florida defines as "sexual activity" does not transmit HIV, including:[92] anal or vaginal penetration of another by *any* other object and the handling or fondling of another for the purpose of masturbation. In these instances, sex workers can face penalties for conduct that has absolutely no risk of exposing another to HIV. In HIV exposure cases involving prostitution, disclosure of HIV status is not a defense, whether

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[84] *Id.*
[85] Katie Thomas, *Equestrian Charged with HIV-Related Offenses*, N.Y TIMES, Apr. 12, 2010, at A12.
[86] *HIV-positive Woman Arrested*, OCALA, Aug. 14, 2009, http://www.ocala.com/article/20090814/ARTICLES/908149971.
[87] *Jacksonville Man Arrested for Criminal Transmission of HIV*, FIRSTCOASTNEWS.COM, July 5, 2010, http://www.firstcoastnews.com/news/local/news-article.aspx?storyid=158235&catid=3#comments. 908149971.
[88] FLA. STAT. ANN §§ 775.082-775.083.
[89] § 381.0041(11)(a).
[90] §§ 775.082-775.083.
[91] § 796.08(5).
[92] § 796.07.

condoms or other protection was used is not a consideration, and ejaculation or the exchange of bodily fluids known to transmit HIV is not required for prosecution.

Though there is an HIV-specific statute for sex workers, many of the reported cases of prosecutions of HIV-positive sex workers have fallen under the criminal "transmission" of HIV statute (see section below on page 32). The only prosecutions of sex workers on record that have not fallen under the criminal "transmission" statute occurred prior to many of Florida's HIV-specific laws being enacted:

- In 1988, an HIV-positive male sex worker was sentenced to five years imprisonment based on his HIV status.[93]
- In August 2009, a 32-year old, HIV-positive sex worker was arrested under Florida's criminal exposure prostitution statute after she offered to perform a sexual act on an undercover officer for $20.[94]

Prosecution under this statute is also possible if an HIV-positive individual "procures" another for prostitution by engaging in sexual activity in a "manner likely to transmit" HIV.[95] At least one case in Florida suggests that "procurement" goes beyond mere solicitation and finds that it requires the inducement of another to provide sexual services to a third party (i.e., a pimp).[96] The meaning of "likely to transmit HIV" is not defined. If "likely" is construed to mean more probable than not, few if any sexual activities would be likely to transmit HIV.[97]

Prosecution for HIV exposure in Florida has occurred under general criminal laws.

At least one case has found that HIV can be considered a deadly weapon for prosecution under general criminal law. In August 2009, a 35-year-old, HIV-positive man in Florida was charged with attempted murder when he allegedly yelled that he had HIV and threatened to kill a police officer with HIV before biting him in the shin and leaving a permanent bruise.[98] He was later convicted of aggravated battery on a law enforcement officer and sentenced to fifteen years in prison. The crime of aggravated battery requires that a person intentionally and knowingly causes great bodily harm or uses a deadly weapon.[99] Many HIV-positive persons convicted of aggravated assault or aggravated battery have been convicted based on their HIV status, with courts finding that the defendant's teeth or bodily fluids (including saliva) used in the assault are "deadly weapons." The officer did not test positive for HIV.

During the trial, the Florida prosecutor told the jury that the police officer had to avoid intimate "contact with his wife or children for fear he could severely affect them," because he was bitten by an HIV-positive person. This statement ignores the fact that the CDC has concluded that there exists only a "remote" possibility that HIV could be transmitted through a bite, and such transmission would have to involve various aggravating factors including "severe trauma, extensive tissue damage, and the presence of blood."[100] The scientific and factual misrepresentations created by criminal HIV exposure laws and the

[93] Mark Journey, *AIDS Carrier in Jail for Soliciting*, ST. PETERSBURG TIMES, Aug. 15, 1990, at 1B.
[94] Jason Schultz, *Riviera Woman With HIV Charged with Prostitution*, PALM BEACH POST, Aug. 21, 2009, at 2B.
[95] FLA. STAT. ANN. § 796.08(5)(West 2010).
[96] *See generally* Register v. State, 715 So.2d 274, 278 (Fla. Dist. Ct. App. 1998) (comparing the meanings of "solicitation" and "procurement" under a statute criminalizing procurement of a minor for prostitution).
[97] Carol L. Galletly & Steven D. Pinkerton, *Toward Rational Criminal HIV Exposure Laws*, 32 J.L. MED. & ETHICS 327, 330 (2004).
[98] David Ovalle, *HIV-Positive Man Who Bit Officer Gets 15 Year Sentence*, Miami Herald, MIAMIHERALD.COM, Aug. 27, 2009, http://www.miamiherald.com/2009/08/27/1203987/hiv-positive-man-who-bit-officer.html.
[99] FLA. STAT. ANN. § 784.045(West 2010).
[100] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted through a human bite?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).

prosecutions of HIV-positive persons only increase the risk that HIV-positive individuals may be prosecuted for conduct that cannot transmit HIV.

HIV-positive persons may face additional felony penalties for committing or attempting to commit an identified crime(s) after a previous conviction for a similar offense.

An HIV-positive person who commits one of the crimes enumerated by statute after a previous conviction for a statutorily enumerated offense can face additional felony charges. Under Florida law, an individual must be tested for HIV if she/he is convicted of, pleads guilty to, or pleads no contest to an offense or attempted offense involving the transmission of bodily fluids (i.e. the sex-based or assault/battery offenses noted in the statute).[101] If an individual tests positive for HIV, knows of her/his HIV status, and commits another such offense involving the transmission of bodily fluids she/he is guilty of an additional felony, punishable by up to five years in prison and/or a $5,000 fine.[102] Although this statute is labeled a "criminal transmission" law, actual transmission of HIV is *not* required.[103]

Felonies that may trigger additional penalties under this statute include:[104]

- Sexual battery
- Incest
- Lewd, lascivious, or indecent assault upon any person less than 16 years of age
- Assault or aggravated assault
- Battery or aggravated battery
- Child abuse or aggravated child abuse
- Abuse or aggravated abuse of any elderly person or disabled adult
- Sexual performance by a person less than 18 years of age
- Prostitution
- Donation of blood, plasma, organs, skin, or other human tissue

It is an affirmative defense to prosecution under this statute if the person exposed knew that the offender was infected with HIV, knew that the action being taken could result in transmission of the HIV infection, and consented to the action voluntarily.[105]

Although the statute enumerates several underlying offenses, the authors are only aware of this law applying in prosecutions of sex workers so far, despite the fact that there is a separate HIV-specific prostitution statute. Such prosecutions include:

- In 2007, a female sex worker was charged with criminal "transmission" of HIV for offering oral sex to an undercover officer.[106]
- A woman was charged with prostitution, resisting arrest, and criminal "transmission" of HIV after negotiating the price of a sex act with an undercover officer.[107] Prosecutors had also considered charging her with attempted murder, even though she told the officer after her arrest that she had HIV and also had condoms in her purse.

[101] FLA. STAT. ANN. § 775.0877 (West 2010).
[102] § 775.0877 (4); §§ 775.082-775.083.
[103] § 775.0877(5).
[104] §§ 775.0877(1)(a)-(n).
[105] §775.087(6).
[106] Michael Scarcella, *Woman Charged with Exposing Men to HIV*, HERALD TRIBUNE, Oct. 10. 2007, at BCE5.
[107] Sue Carlton, *HIV-Positive Woman Free of Attempted Murder Charge*, ST. PETERSBURG TIMES, June 18, 1996, at 4B.

Florida courts have also imposed sentencing enhancements based on HIV status.

Early in the epidemic, Florida courts imposed sentence enhancements based on a person's HIV-positive status. The cases noted here are from the late 1980s and mid-1990s, and there are no recent cases, to the authors' knowledge, demonstrating that Florida courts continue to apply sentence enhancements based on HIV status. The following cases are included as a comprehensive review of Florida's approach to HIV criminalization, but are not necessarily reflective of current trends in criminal sentencing in Florida.

In *Morrison v. State*, the HIV-positive defendant was convicted of aggravated battery and was sentenced to ten years imprisonment and ten years of parole.[108] The trial court justified its departure from the sentencing guidelines because in the course of the robbery the defendant bit a 90-year-old man to the bone who later tested positive for HIV. Confirming the lower court's sentencing, the court of appeals held that the departure was justified due to the nature of the crime and that HIV could give rise to AIDS.

One Florida case has held that an HIV-positive defendant's status could be enhanced even if there was no proof that the defendant knew he was HIV-positive at the time of the crime. In *Cooper v. State,*[109] the defendant was convicted of aggravated battery, solicitation, and sexual battery and sentenced to thirty years imprisonment, reflecting an upward departure from the sentencing guidelines. Four days prior to trial, the defendant received test results that showed he had tested positive for HIV. Though the jury never received this information, the sentencing judge found that the defendant's total disregard of the likelihood that the complainant would be exposed to HIV through the sexual contact supported an enhanced sentence. On appeal, the court agreed with the sentencing holding that "[b]ecause of his lifestyle, Cooper knew or should have that he had been exposed to the AIDS virus and that by sexual battery upon his victim there was a strong likelihood that the victim would be exposed to AIDS."[110] By "lifestyle" the court was referring to the fact that the defendant had been a "homosexual for years."[111] There was no evidence presented that showed Cooper knew of his HIV status at the time of the assault and, in fact, had only tested positive immediately before trial. This opinion rests on the assumption that gay men should know that they have been exposed to HIV even though they have not tested positive.

In *Brooks v. State,*[112] a judge sentenced a sex worker convicted of theft to a sentence above the state sentencing guidelines because she had AIDS, despite the fact that the crime had nothing to do with her HIV status. On appeal, the sentence was reversed because her HIV status was in no way relevant to the crime.

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, it should not be used as a substitute for legal advice.

[108] 673 So.2d 953 (Fla. Dist. Ct. App. 1996).
[109] 539 So. 2d 508 (Fla. Dist. Ct. App. 1989).
[110] *Id.* at 511.
[111] *Id.* at 512.
[112] 519 So.2d 1156 (Fla. Dist. Ct. App. 1988).

Georgia Statute(s) that Allow for Criminal Prosecution based on HIV Status:

GA. CODE ANN. § 16-5-60(C)

Reckless conduct; HIV-infected persons
Felony (punishable by imprisonment for not more than ten years)

Any person who knows that she/he is HIV-infected is guilty of a felony if she/he, without first disclosing her/his HIV status, (1) knowingly has sexual intercourse or performs or submits to any sexual act involving the sex organs of one person and the mouth or anus of another person; (2) knowingly shares a hypodermic needle or syringe with another person; (3) offers or consents to perform an act of sexual intercourse for money; (4) solicits another to perform or submit to an act of sodomy for money; or (5) donates blood, blood products, other body fluids, or any body organ or body part.

GA. CODE ANN. § 16-5-60(D)

Reckless conduct; HIV-infected persons
Felony (punishable by imprisonment for between five & twenty years)

A person who knows she/he is HIV-infected who commits an assault with the intent to transmit HIV, using her/his body fluids (blood, semen, or vaginal secretions), saliva, urine, or feces upon a peace or correctional officer while the officer is engaged in the performance of her/his official duties or on account of the officer's performance of her/his official duties is guilty of a felony.

HIV-positive status must be disclosed to sexual partners to avoid criminal penalties.

Georgia's HIV exposure statute targets HIV-positive persons who fail to disclose their HIV status prior to engaging in anal, oral, and penile-vaginal sex with another person. A violation of the statue results in felony penalties of up to ten years imprisonment. Neither the intent to transmit HIV nor the actual transmission of HIV is necessary for prosecution.

Disclosure of one's HIV status is the only affirmative defense to prosecution. A defendant's viral load is not a consideration, and it is no defense if protection, such as a condom, was used during sexual activities. It is a violation of the statute even if an HIV-positive person fails to disclose her/his status and performs oral sex on an HIV-negative person despite the fact that there is at best a remote risk of HIV exposure from such activity.

Though disclosure is a defense to prosecution, there are difficulties in proving whether or not disclosure actually occurred in these situations and such evidence normally depends on the words of one person against another. In a 2008 case, an HIV-positive woman was sentenced to eight years

imprisonment and two years probation for reckless conduct when she allegedly engaged in unprotected sexual intercourse without disclosing her HIV status.[113] She was convicted, despite the fact that two witnesses testified that the woman's sexual partner was aware of her HIV-positive status, and the defendant testified that her sexual partner knew her HIV-positive status because it had been published on the front page of a local newspaper.

In a January 2009 case, a 38-year-old man from Georgia was sentenced to two years in jail and eight years probation after pleading guilty to reckless conduct for having sex with a woman without telling her he was HIV-positive.[114] The HIV-positive man and his partner, who tested negative for HIV, met at a housing center for people living with HIV. The fact that he was living at a home solely for people living with HIV was not enough to be considered disclosure for the purposes of the reckless conduct statute.

In November 2010, an HIV-positive man was charged with rape and reckless conduct for allegedly sexually assaulting a woman.[115]

Engaging in prostitution without disclosing HIV status is a felony.

Georgia's reckless conduct law imposes criminal penalties for HIV-positive persons who do not disclose their status before engaging in solicitation or acts of prostitution. A maximum sentence of ten years imprisonment can be imposed if an HIV-positive person is aware of her/his HIV status and fails to disclose it before (1) offering or consenting to engage in sexual intercourse for money, or (2) soliciting another to submit to or perform oral or anal sex for money.[116] Neither the intent to transmit HIV nor actual transmission is required. A conviction for prostitution is normally a misdemeanor,[117] but is prosecuted as a felony based on one's HIV-positive status.

This statute penalizes an individual for being HIV-positive, regardless of whether she/he exposed another to a significant risk of HIV transmission. It is not a defense if protection was used during alleged acts of prostitution because *offering* or *soliciting* to engage in sexual intercourse is sufficient for prosecution and actual sexual conduct is not required.

HIV-positive status must be disclosed before sharing needles.

Georgia imposes criminal penalties for HIV-positive persons sharing needles or syringes. Up to ten years imprisonment may follow if an HIV-positive individual is (1) aware of her/his HIV status, (2) uses a needle or syringe for the injection of drugs or withdrawal of bodily fluids, and (3) shares that needle with another without disclosing her/his HIV status.[118] It is a complete defense if HIV status is disclosed before needle-sharing. Neither the intent to transmit HIV nor actual transmission are required.

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[113] Ginn v. State, 667 S.E.2d 712, 713 (Ga. Ct. App. 2008).
[114] Amy Leigh Womack, *HIV-Positive Man Sentenced for Not Disclosing HIV Status to Partner*, MACON.COM, Jan. 13, 2009, http://www.macon.com/2009/01/13/584845/hiv-positive-man-sentenced-for.html.
[115] Andria Simmons, *HIV-positive Man to Stand Trial on Rape Charge*, ATLANTA J. CONST., Nov. 12, 2010, http://www.ajc.com/news/gwinnett/hiv-positive-man-to-738690.html.
[116] GA. CODE ANN. §§ 16-5-60(c)(3)-(4)(West 2010).
[117] § 16-6-9.
[118] § 16-5-60(c)(2).

HIV-positive status must be disclosed before donating blood or body tissues.

It a felony punishable by up to ten years imprisonment if an HIV-positive individual is aware of her/his HIV status and fails to disclose her/his status before donating blood, blood products (i.e., plasma, platelets), other bodily fluids, or any other body organ or body part.[119] Neither the intent to transmit HIV nor actual transmission are required.

Assaulting a peace or correctional officer using bodily fluids with intent to transmit HIV is a felony.

Georgia's reckless conduct/endangerment statute includes a provision that is tailored to cases involving peace officers and correctional officers. It is a felony, punishable by five to twenty years in prison, for individuals who are aware that they are HIV-positive to commit an assault against a peace or correctional officer engaged in her/his duties with the *intent* to transmit HIV using her/his blood, semen, vaginal secretions, saliva, urine, or feces.[120] This statute punishes conduct that poses only remote possibilities of HIV exposure and, though intent is considered an element of the prosecution, many of the bodily fluids listed cannot transmit HIV.

In *Burk v. State*,[121] an HIV-positive man who allegedly threatened to transmit HIV to a corrections officer was originally charged with aggravated assault with intent to murder after he struck the officer, grabbed his arm, and attempted to bite him. The inmate was later convicted of reckless conduct (what was then referred to as "reckless endangerment"), an offense which required that he disregard a substantial risk of harming or endangering the safety of the officer.[122] Despite the fact that the CDC has long maintained that there exists only a "remote" possibility that HIV could be transmitted through a bite and such transmission would have to involve various aggravating factors including "severe trauma, extensive tissue damage, and the presence of blood,"[123] the Georgia Court of Appeals found Burk's alleged attempt to bite the officer sufficient to uphold his conviction for reckless conduct. Contrary to the CDC's position, a physician testified at trial that HIV transmission from a human bite was "very strongly probable" and that he "did not see why" HIV could not be transmitted through saliva.[124] Based off of this testimony, the court affirmed the defendant's conviction, finding that the defendant knowing his HIV status and purposefully biting the officer amounted to reckless conduct, despite the fact that biting was not conduct proscribed under Georgia Code § 16-5-60.

The conviction in Burke reflects the issues associated with "expert" testimony on HIV transmission and exposure. HIV-positive persons can be convicted for conduct that presents at best a remote possibility of HIV exposure or transmission if the expert testimony fails to provide scientifically supported facts on HIV.

HIV-positive persons have also been prosecuted under aggravated assault charges.

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[119] § 16-5-60(c)(5).
[120] § 16-5-60(d).
[121] 478 S.E.2d 416 (Ga. Ct. App. 1996). *See also* Scroggins v. State, 401 S.E.2d 13 (Ga. Ct. App. 1990) (affirming conviction for aggravated assault with intent to murder for bite on police officer by HIV-positive defendant).
[122] *Burk,* 478 S.E.2d at 417.
[123] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted through a human bite?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).
[124] *Burk,* 478 S.E.2d at 417.

In *Scroggins v. State*, the defendant, while struggling with a police officer, sucked extra saliva into his mouth and then bit the officer.[125] When the defendant was treated at the hospital he told a nurse he was HIV-positive and laughed when the officer who was bit asked the defendant about his status. He was convicted of aggravated assault with intent to murder. On appeal, the Georgia Court of Appeals found that the impossibility of transmitting HIV via a bite and/or saliva was not a defense as long as Scroggins believed HIV could be transmitted in such a manner. The court ruled that a wanton and reckless state of mind could be the equivalent of a specific intent to kill for the purposes of the charges, and that Scroggins biting the officer while knowing that he was HIV-positive was sufficient evidence to establish a wanton and reckless disregard for whether HIV was transmitted.

A person commits aggravated assault when there is an intent to murder, rape, or rob someone using a deadly weapon that does or is likely to result in serious bodily injury.[126] Despite the fact that the CDC has long maintained that there exists only a "remote" possibility that HIV could be transmitted through a bite and such transmission would have to involve various aggravating factors including "severe trauma, extensive tissue damage, and the presence of blood," Georgia's application of its aggravated assault statute ignores these facts and continues to prosecute HIV-positive persons for acts that, at best, have a remote possibility of transmitting HIV.[127] The CDC has also concluded that spitting alone has never been shown to transmit HIV.[128]

Other prosecutions under the aggravated assault statute include:

- In August 2009, a 42-year-old HIV-positive man was charged with aggravated assault after he bit an Atlanta police officer, allegedly shouting "I have full-blown AIDS" and stating that his bite would infect the officer with HIV.[129] He later received eighteen months for aggravated assault.[130]
- In a July 2008 case, a 43-year-old, HIV-positive woman was charged with aggravated assault when she spat in the face of another person. The woman pleaded guilty and was sentenced to three years in jail.[131]

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[125] 401 S.E.2d 13 (Ga. Ct. App. 1990) overruled on other grounds Dugan v. State, 502 S.E.2d 726 (Ga. 1998).
[126] GA. CODE. ANN. § 16-5-21 (West 2010).
[127] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted through a human bite?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).
[128] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted by being spit on by an HIV infected person?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).
[129] Stephanie Ramage, *Too Lenient?*, SUNDAYPAPER.COM, Aug. 30, 2009, http://www.sundaypaper.com/More/Archives/tabid/98/articleType/ArticleView/articleId/4452/Too-lenient.aspx.
[130] *Id.*
[131] *Woman with HIV Gets 3 Years for Spitting in Face*, NBC AUGUSTA, July 23, 2008, http://www.nbcaugusta.com/news/local/25798434.html?corder=regular.

Hawaii Statute(s) that Allow for Criminal Prosecution based on HIV Status:

No specific statute on record.

No explicit statute

There are no statutes explicitly criminalizing HIV exposure or transmission in Hawaii. However, in some states, HIV-positive people have been prosecuted for HIV exposure under general criminal laws, such as reckless endangerment and aggravated assault. At the time of this publication, the authors are not aware of a criminal prosecution of an individual on the basis of that person's HIV status in Hawaii.

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Idaho Statute(s) that Allow for Criminal Prosecution based on HIV Status:

IDAHO CODE ANN. § 39-608

Felony: transfer of bodily fluids which may contain HIV

Any person who exposes another in any manner with the intent to infect or, knowing that he or she has HIV, transfers or attempts to transfer any of her/his body fluid, tissue, or organs to another person is guilty of a felony. It is an affirmative defense if:

1. The sexual activity took place between consenting adults after full disclosure by the accused of the risk of HIV transmission.
2. The transfer of body fluid, tissue, or organs occurred after advice from a licensed physician that the accused was noninfectious.

"Body fluid" means semen (with or without sperm), blood, saliva, vaginal secretion, breast milk, and urine.

"Transfer" means:

- Engaging in sexual activity by:
  - Genital-genital contact; or
  - Oral-genital contact; or
  - Anal-genital contact;
- Permitting the use of an unsterilized hypodermic syringe, needle, or similar device; or
- Giving blood, semen, body tissue, or organs for transfer to another person.

Sentences and Fines: Up to 15 years in prison and/or up to a $5,000 fine.

IDAHO CODE ANN. § 39-601

Misdemeanor: knowingly exposing another to a venereal disease

It is unlawful for anyone infected with HIV to knowingly expose another person to HIV infection.

To avoid the risk of prosecution, HIV status must be disclosed to sexual partners.

Individuals living with HIV in Idaho should be aware that it is against the law to engage in sexual intercourse without disclosing one's HIV status. It is a felony, punishable by to up fifteen years in

prison and/or a $5,000 fine, for an HIV-positive person to act with intent, or knowing one's HIV status, to transfer or attempt to transfer bodily fluids through any genital-to-genital, mouth-to-genital, or genital-anal contact.[132] Though intent to transfer HIV is an element of the crime, simply knowing one's HIV status and failing to disclose that status is enough for prosecution. Actual transmission is not required.

An HIV-positive person engaging or attempting to engage in anal, oral, or vaginal sex has a defense under this statute if she/he can prove that (1) the sex was consensual and (2) her/his partner was informed "of the risk of such activity."[133] Informing a partner only of one's HIV-positive status, without disclosing the risk of transmission, is not a sufficient defense on the face of this statute. It is not a defense of condoms, or other protection, was used.

But whether or not disclosure actually occurred is often open to interpretation and always depends on the words of one person against another. In *State v. Thomas*, an HIV-positive man was convicted under Idaho's statute and sentenced to fifteen years in prison for engaging in anal and oral sex, without ejaculating, with a transsexual woman without disclosing his HIV status.[134] At trial, the defendant questioned his accuser's credibility regarding her denial that he had disclosed his HIV-positive status, suggesting that she had a history of drug use, psychological problems, a reputation "untruthful and dramatic" behavior, and that she had several drinks before having sex with him that would have affected her memory of the evening's events. Friends of the complainant, however, testified that they were in her apartment, could hear her sexual encounter, and when they, knowing of the defendant's status, told her he was HIV-positive, she was very upset and alluded to the fact that she had no knowledge of his HIV status. The Idaho Court of Appeals saw this testimony as sufficient to sustain the jury's guilty verdict despite the contradictions in testimonies.

In 2009, after serving fifteen years in prison, the defendant in *State v. Thomas* pleaded guilty to two more charges of exposing women to HIV. A judge chastised the defendant for giving his sexual partners "a potential death sentence" and sentenced him to thirty years in prison with the possibility of parole after twenty years.[135] The woman in this case did not test positive for HIV, but transmission of HIV is not an element of the crime and, as such, would not have been a consideration to the conviction. The same defendant was also charged under Idaho's exposure law during a 1990 statutory rape case.[136]

HIV-positive persons prosecuted under Idaho's felony HIV exposure law may have a defense if they can prove that a licensed physician informed them that they were "noninfectious" (could not transmit HIV to others).[137] This could occur if a person's viral load was undetectable.

In 2010, a man was charged with knowingly transferring bodily fluids with HIV for failing to disclose his status to sexual partners he had met on the Internet.[138] The man told detectives that he

[132] IDAHO CODE ANN. § 39-608 (2010).
[133] § 39-608(3)(a).
[134] State v. Thomas, 983 P.2d 245, 246 (Idaho Ct. App. 1999).
[135] Orr, *Former Boise State/NNU Basketball Player Sentenced for Exposing Others to HIV*, IDAHO STATESMAN, Sept. 16, 2009, http://www.idahostatesman.com/2009/09/16/902407/former-boise-statennu-basketball.html.
[136] *Id.*
[137] IDAHO CODE ANN. § 39-608(3)(b)(2010).

failed to tell his sexual partners, with whom he had had unprotected sex, that he was HIV-positive after he had been booked on an unrelated DUI conviction.

HIV-positive persons have also been prosecuted under Idaho's statute for engaging in acts that are not known to transmit HIV. In *State v. Mubita*,[139] an HIV-positive man was sentenced to forty-four years in prison (eleven counts of transferring bodily fluids) with a possibility of parole after four years for crimes including performing oral sex on his female partner and ejaculating on her thigh.[140] On appeal, defense counsel argued that it was factually impossible to violate Idaho's felony exposure law, intended to criminalize "knowingly expos[ing] another person to AIDS," because oral sex, when being performed by an HIV-positive party, and ejaculating on intact skin, has no, or only a remote, possibility of transmitting HIV. The Idaho Court of Appeals did not go beyond the plain language of Idaho's felony exposure law and found that because the man engaged in oral sex, which is a prohibited act unless there is disclosure, and the law specifically included saliva in its list of "bodily fluids" capable of transmitting HIV, the man violated Idaho Code Ann. §39-608. "Bodily fluids" that can be transferred under Idaho law include saliva and urine in addition to blood, semen, vaginal secretions, and breast milk, despite scientific evidence that HIV is not transmitted through saliva or urine.

Idaho's definition of bodily fluids disregards scientific facts surrounding the risks of HIV transmission, only adding to public confusion concerning how the disease is transmitted and worsening the stigma faced by HIV-positive persons. It ignores the fact that the CDC has long maintained that saliva and urine have not been found to transmit HIV. Breast milk is included in this statute's list of "bodily fluids," but breastfeeding is not included in a list of activities that "transfer" bodily fluids.[141]

Sharing needles/syringes is a felony.

Idaho's HIV statute specifically targets intravenous drug users and others who share their needles and syringes. To avoid prosecution, HIV-positive individuals should not share needles, syringes, and similar drug paraphernalia capable of transferring fluids through the skin. It is a felony, punishable by up to fifteen years in prison and/or a $5,000 fine, for an individual who is aware that she/he is HIV-positive to "transfer" bodily fluids by allowing others to use their hypodermic syringes, needles, or similar devices without sterilization.[142]

Neither the intent to transmit HIV nor actual transmission is required for conviction. Disclosure of HIV status is not a defense to a syringe-sharing charge, it is only a defense for sexual activity.[143] An HIV-positive person sharing needles or syringes only has a defense to prosecution if she/he can

[138] *Boise Man Charged with Transferring HIV*, IDAHO PRESS TRIBUNE, Sept. 14 2010, http://www.idahopress.com/news/article_bbfc76ac-c032-11df-9d38-001cc4c002e0.html.
[139] 188 P.3d 867, 871 (Idaho 2008).
[140] *Id.* at 883.
[141] IDAHO CODE ANN. § 39-608(2)(a)-(b). Christina M. Schriver, *State Approaches to Criminalizing the Exposure of HIV*, 21 N.ILL.U.L. Rev. 319, 328 (2001).
[142] IDAHO CODE ANN. § 39-608(2)(b)(2010).
[143]§ 39-608(3)(a).

prove that a licensed physician advised them that they were "noninfectious" (not capable of infecting others with HIV).[144]

HIV status must be disclosed before donating blood, semen, body tissues, or organs.

It is a felony, punishable by up to fifteen years in prison and/or a $5,000 fine, for an individual who is aware that she/he is HIV-positive to "transfer" bodily fluids to another by giving blood, semen, organs, or body tissues to any person, blood bank, hospital, or medical facility for the purposes of transfer to another person.[145] Neither the intent to transmit HIV nor actual transmission is required. However, an HIV-positive person donating blood, semen, organs, or body tissues does have a defense if she/he can prove that the donation(s) occurred after a licensed physician advised that she/he was "noninfectious" (not capable of infecting others with HIV).[146]

Prosecution may result from exposing another to HIV, but the meaning of "exposing" is not defined.

Idaho has a generalized, catch-all HIV exposure statute, Idaho Code Ann. § 39–601, in addition to the felony statute criminalizing such activities as needle-sharing and unprotected sexual intercourse (as discussed above). This is a communicable disease control statute and such statutes are rarely used in prosecutions.

In Idaho it is a misdemeanor for an HIV-positive person to knowingly expose another to HIV infection.[147] The penalties for violating this law are not specified, although penalties for exposing others to syphilis, gonorrhea, or chancroid may include up to six months in prison and/or up to a $300 fine.[148] Unlike Idaho's felony exposure statute, discussed above, disclosure is not a defense. Neither the intent to transmit HIV or actual transmission is required.

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[144] § 39-608(3)(b).
[145] § 39-608(2)(b).
[146] § 39-608(3)(b).
[147] § 39-601.
[148] § 39-607.

Illinois Statute(s) that Allow for Criminal Prosecution based on HIV Status:

720 ILL. COMP. STAT. § 5/12-16.2

"Criminal transmission of HIV"

A person who knows that she/he is infected with HIV commits criminal transmission of HIV if she/he:

(1) Engages in contact with another person involving the exposure of the body of one person to a bodily fluid of another in a manner that could result in HIV transmission ("intimate contact");

(2) Transfers, donates, or provides his or her blood, tissue, semen, organs or other potentially infectious body fluids for administration (e.g., transfusion) to another person; or

(3) In any way transfers to another any non-sterile IV or intramuscular drug paraphernalia.

The actual transmission of HIV is not a required element of this crime. It is an affirmative defense that the person exposed knew the infected person was HIV-positive, knew the action could result in infection, and consented with that knowledge.

Violation of this statute is a Class 2 felony.

720 ILL. COMP. STAT. § 5/8-4(c)(4)

Penalties for attempt

The sentence for attempt to commit a Class 2 felony is the sentence for a Class 3 felony.

730 ILL. COMP. STAT. § 5/5-4.5-35 - 40

Penalties

For a Class 2 felony, not less than 3 years in prison and not more than 7 years.

For a Class 3 felony, not less than 2 years in prison and not more than 5 years.

730 ILL. COMP. STAT. § 5/5-4.5-50

Fines

A felony offender may be sentenced to pay a fine not to exceed, for each offense, $25,000 or the amount specified in the offense, whichever is greater.

HIV-positive persons may be imprisoned for exposing others to their "bodily fluids."

HIV-positive persons may face prosecution for engaging in a broad range of contact. There have been numerous prosecutions in Illinois for HIV exposure under the state's HIV-specific "criminal transmission" law. Though the law is entitled "criminal transmission," neither the intent nor the transmission of HIV is required for prosecution.

It is a Class 2 felony punishable by three to seven years in prison[149] and a $25,000 fine,[150] for a person who is aware that she/he is HIV-positive to engage in "intimate contact" with another.[151] "Intimate contact" with another is defined as the exposure of the body of one person to the bodily fluid of another person in a manner that could result in the transmission of HIV.[152] Prosecutions under the statute have included the following cases:

- In one of Illinois' earliest prosecutions for HIV exposure, an HIV-positive man pleaded guilty to "criminal transmission" of HIV in February 1992 after sexually assaulting a woman.[153]
- In February 1993, a 37-year old, HIV-positive man was charged with "criminal transmission" of HIV and attempted murder when he allegedly attacked a nurse and stuck her with a needle filled with his blood. The man died before trial.[154]
- A 30-year old, HIV-positive sex worker was charged with "criminal transmission" of HIV in May 1999 after she was discovered having sex with a man in exchange for money. A condom wrapper was found at the scene of the woman's arrest. It is not know whether the man later tested positive for HIV but that would not be relevant to prosecution, nor is it relevant that a condom may have been used during sex.[155]
- In October 1999, a 36-year old, HIV-positive man pleaded guilty to "criminal transmission" of HIV after he allegedly threatened police officers with HIV infection and attempted to splatter them with his blood during an interrupted suicide attempt.[156] The man's wrists were already cut and bleeding before the officers arrived.
- An HIV-positive man was charged with "criminal transmission" of HIV in August 2004 after he sexually assaulted a 17-year old girl.[157] It is not known whether the girl tested positive for HIV but transmission is irrelevant to prosecution.

[149] 730 ILL. COMP. STAT. ANN. 5/5-4.5-35(a) (West 2010).
[150] 5/5-4.5-50(b).
[151] 5/12-16.2.
[152] 5/12-16.2(b).
[153] *Man Pleads Guilty to HIV Transmission*, CHI. TRIB, Feb. 25, 1992, at 3-D.
[154] Christian Hawes*, Man with AIDS Held in Attack,* CHI. TRIB., Feb. 28, 1993, at 3-L; Teresa Jimenez, *HIV Transmission Law Faces a Test*, CHI. TRIB., Feb. 13, 1996, at 1-L.
[155] Mark Shuman, *Prostitution Suspect faces HIV Charge,* CHI. TRIB., May 6, 1999, at 2-NW.
[156] Art Barnum, *Man Pleads Guilty to Trying to Pass HIV*, CHI. TRIB., Oct. 21, 1999, at 1-D.
[157] Patrick Rucker, *HIV-positive Suspect Charged in Rape of Teen,* CHI. TRIB., Aug. 18, 2004, at 3-SSW.

- In 1993, an HIV-positive man stuck a syringe with his blood into a nurse and was originally charged with criminal transmission of HIV.[158] The charges were later changed to attempted murder but the man died before trial. The nurse did not test positive for HIV.

An individual prosecuted under Illinois' criminal transmission law has an affirmative defense if she/he can prove that the individual exposed to HIV was (1) aware that she/he was HIV-positive, (2) knew that the alleged "intimate contact" could result in HIV infection, and (3) consented to HIV exposure with knowledge of these risks.[159] It is not a defense if condoms or other protection was used during sexual relations, though such use has been demonstrated to be highly effective in preventing HIV transmission.[160]

Several individuals in Illinois have been prosecuted for allegedly failing to disclose their positive HIV status to sexual partners. The following cases serve as examples:

- A 39-year old sex worker was charged with "criminal transmission of HIV" in December 1996, when she allegedly failed to disclose to a man that she had AIDS before having sex with him for money.[161]
- In December 2004, a 33-year old, HIV-positive man was charged with criminal transmission of HIV for having sex with his girlfriend without disclosing his HIV status. The man's HIV status was discovered in a letter from hospital officials during a police search related to another investigation. It is not known whether the woman tested positive for HIV or whether protection was used during sexual intercourse, but these facts would be irrelevant to prosecution.[162]
- A 42-year-old man pleaded guilty to criminal transmission of HIV in 2006 after he failed to disclose his HIV status before engaging in unprotected sex with a 19-year old woman. The man was sentenced to six years in prison.[163]

Illinois' definition of "bodily fluids" for the purpose of its HIV exposure law does not limit its definition only to fluids known to transmit HIV. Even though the CDC has long maintained that saliva, tears, and sweat do not expose others to a risk of HIV transmission, these bodily fluids are not excluded from consideration under Illinois' criminal transmission law.[164] This means that spitting, biting, scratching, and other activities pose, at best, only *theoretical* risks of HIV transmission may be subject to prosecution. There have been numerous prosecutions in Illinois for criminal

[158] Teresa Jimenez, *HIV Transmission Law Faces A Test*, CHICAGO TRIBUNE, Feb. 13, 1996, at Metro Lake 1.
[159] 720 ILL. COMP. STAT. ANN. 5/12-6.2(3)(d) (West 2010).
[160] CTR. FOR DISEASE CONTROL & PREVENTION, *Condoms and STDs*, http://www.cdc.gov/condomeffectiveness/latex.htm (last visited Oct 19, 2010).
[161] Mark Shuman, *Woman Accused of HIV Crime*, CHI. TRIB., Dec. 10, 1996, at 3-NW.
[162] Krystyna Slivinski, *Elgin Man Charged with HIV Exposure,* CHI. TRIB., Dec. 16, 2004, at 2-NW.
[163] Dave Fopay, *Man Pleads Guilty in Coles County for Knowingly Spreading HIV*, HERALD-REVIEW.COM, Feb. 16, 2010, http://www.herald-review.com/news/local/article_77a9af98-13b8-5a12-aa55-88997f84b5b3.html.
[164] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission,* (March 25, 2010), http://www.cdc.gov/hiv/resources/qa/transmission.htm.

transmission of HIV stemming from an HIV-positive person biting someone, despite the fact that the CDC has concluded that there exists only a "remote" possibility that HIV could be transmitted through a bite and such transmission would have to involve various aggravating factors including "severe trauma, extensive tissue damage, and the presence of blood."[165]

The following case studies illustrate how activities posing only theoretical risks of HIV transmission have be prosecuted in Illinois:

- In March 1993, a 35-year old, HIV-positive woman was charged with criminal transmission of HIV when she allegedly refused to leave a hospital after treatment, biting a security guard and spitting at others in the process.[166] Her bite did not break the guard's skin.
- In April 1996, a 45-year old, HIV-positive man received a ten-year prison sentence after he allegedly forged a check at a Sam's Club, fled the store when employees became suspicious, and bit a man attempting to stop him.[167] In addition to fraud and forgery charges, the man was charged with criminal transmission of HIV. The HIV charge was dropped in exchange for a guilty plea on his other charges and a lesser charge of aggravated battery. Despite the fact that biting has been shown to present only a remote risk of transmitting HIV, a state attorney suggested that HIV infection would be a "concern that is going to follow this victim the rest of his life."
- In January 2006, an HIV-positive man was charged with aggravated battery and criminal transmission of HIV when he allegedly bit a sheriff's deputy. The man died in a car crash shortly before his initial court hearing.[168]

HIV-positive persons have also been imprisoned for *attempting* to transmit HIV, regardless of whether any exposure would have been possible if the task had been completed. In Illinois, it is a Class 3 felony, punishable by two to five years in prison[169] and a $25,000 fine,[170] to attempt to criminally transmit HIV.[171] In a February 2003 case concerning attempt, a 47-year old, HIV-positive woman pleaded guilty to attempted criminal transmission of HIV after leaving a bar with a man to go to his home to engage in intimate contact.[172] She was sentenced to the six months in county jail for time she had already served since her arrest the previous September, plus two years probation.

In Illinois, as in many states, it is not a defense if HIV transmission was impossible under the

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[165] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted through a human bite?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).
[166] Jerry Crimmins, *Police: Woman with HIV Bit Security Guard*, CHI. TRIB., Mar. 30, 1993, at 2-D.
[167] Teresa Jimenez, *Biter is Given a 10-year Sentence*, CHI. TRIB., Apr. 19, 1996, at 7-N.
[168] Sara Olkon, *2 in Berwyn Crash Identified*, CHI. TRIB., Aug. 18, 2006, at 1-NRW; Andrew Davis, *Man Killed Has Been Charged with Transmitting HIV*, WINDYCITYMEDIAGROUP.COM, Aug. 23, 2006, http://www.windycitymediagroup.com/gay/lesbian/news/ARTICLE.php?AID=12441.
[169] 730 ILL. COMP. STAT. ANN. 5/5-4.5-40(a) (West 2010).
[170] 5/5-4.5-50.
[171] 5/8-4(c)(4).
[172] Art Barnum, *Woman Pleads Guilty in HIV Case,* CHI. TRIB., Feb. 4, 2003, at 3-D.

circumstances.[173] Even a verbal offer to engage in "intimate contact" may result in prosecution despite the fact that the completed act would not have had any risk of HIV exposure (i.e.: a hand job, fingering, or performing oral sex). In 1991, a 34-year old, HIV-positive sex worker was sentenced to three years in prison after she agreed to have sex with an undercover police officer.[174] She was released from prison by the Governor of Illinois shortly before her death.[175]

In another case, a 26-year old, allegedly HIV-positive sex worker was arrested and charged with attempted criminal transmission of HIV when she walked up to a police officer and offered to have sex with him for money.[176] In each of these cases it did not matter that there was no evidence to show that even if the proposed act had been completed there would have been a risk of HIV transmission, if disclosure would have occurred, or condoms or other protection would have been used.

There have been repeated unsuccessful legal challenges to the constitutionality of Illinois' criminal HIV transmission law.

Despite its flawed language and broad scope, the Illinois HIV criminal transmission law has survived multiple legal challenges arguing that its language is unconstitutionally vague. In *People v. Dempsey,*[177] a 34-year old, HIV-positive man was convicted of aggravated criminal sexual assault and criminal transmission of HIV when he allegedly ejaculated in the mouth of his 9-year old brother.[178] On appeal, the defendant argued that Illinois' criminal transmission law was unconstitutionally vague, as the phrase "could result in the transmission of HIV" is overbroad and fails to define precisely what conduct is prohibited.[179] He also contended that the Illinois legislature's failure to define "bodily fluid" meant that exposure to saliva and tears could conceivably be criminalized, and an individual interpreting the law would be left to speculate about the legality of activities that pose no risk of transmitting HIV, such as spitting.

The Illinois Appellate Court rejected this challenge, finding that the defendant's conduct fell squarely within the language of Illinois' criminal transmission statute, and that the law was not unconstitutionally vague as applied to him. The court reasoned that the defendant clearly exposed his brother to HIV because semen was well known as a "transmitter of HIV" and oral sex was a recognized route of HIV transmission. Given that the defendant's conduct was clearly targeted under Illinois' HIV transmission statue, the court found that he was given fair notice that his conduct would be considered criminal. The defendant did not have standing to challenge the statute on hypothetical scenarios that were not reflective of his conduct.

In 1994, the Illinois Supreme Court also ruled that the state's transmission law was not unconstitutionally vague.[180] *People v. Russell* concerned two prosecutions for HIV "transmission"[181]

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[173] 720 ILL. COMP. STAT. ANN. 5/8-4(b).
[174] Rob Karwath, *Prostitute with AIDS Wants Out,* CHI. TRIB., Aug. 29, 1991, at 8-NW.
[175] *Edgar Frees Prostitute with AIDS*, CHI. TRIB., Oct. 23, 1991, at 6-C.
[176] Jeff R. Grandziel, *Woman Charged with Prostitution*, CHI. TRIB., Sept. 23, 1997, at 3-NW.
[177] 610 N.E.2d 208 (Ill. App. Ct. 1993).
[178] *Dempsey,* 610 N.E.2d at 210. The opinion does not indicate that the nine-year-old boy was infected with HIV as a consequence.
[179] *Id.* at 222.
[180] People v. Russell, 630 N.E.2d 794 (Ill. 1994).

that were consolidated into one appeal. In one case, an HIV-positive woman was charged with criminal transmission of HIV when she engaged in consensual sexual intercourse allegedly without disclosing her status to her partner.[182] In the second, an HIV-positive man was charged with the same offense after he raped a woman with knowledge of his HIV status. In both cases, the trial judges found Illinois' criminal transmission law to be unconstitutionally vague.

The Illinois Supreme Court reversed the trial courts decisions finding that the specific conduct of the defendants were clearly addressed by the statute, and that the argument that the Illinois' criminal transmission law "might open the innocent conduct of others to possible prosecution is a matter of pure speculation and conjecture."[183]

Despite the fact that Illinois' HIV "criminal transmission" statute has and continues to lead to numerous prosecutions of conduct that pose only theoretical or remote risks of HIV transmission, provides limited definitions of what conduct could be criminally liable, and does not consider ameliorating factors such as condom use, it has managed to withstand constitutional challenge.

HIV-positive persons are prohibited from donating or providing blood, tissue, semen, organs, or bodily fluids.

HIV-positive persons also are subject to prosecution and imprisonment if they donate blood, bodily fluids such as semen, and human tissue. It is a Class 2 felony, punishable by three to seven years in prison[184] and a $25,000 fine,[185] for an HIV-positive person to donate, transfer, or provide blood, tissue, semen, organs, or "other potentially infectious bodily fluids" for transfusion, transplant, insemination, or administration to another.[186]

The meaning of "potentially infectious bodily fluids" is undefined in the statute. Taken literally, any bodily fluid containing any amount of HIV virus could "potentially" infect another if the odds of HIV transmission are greater than zero. Neither the intent to transmit HIV nor actual transmission is required for liability.

Individuals prosecuted under this statute have a defense if they can prove that the individual exposed to a blood, fluid, organ, or tissue donation (1) was aware that her/his donor was HIV-positive, (2) knew that accepting a donation could result in HIV infection, and (3) consented to HIV exposure knowing of this risk.[187]

Individuals with HIV may also be prosecuted for attempting to donate blood, semen, organs or other human tissues, and bodily fluids. Such offenses are Class 3 felonies, punishable by two to five

[181] As noted earlier, charges brought under Illinois' HIV exposure statute are called "criminal transmissions," even though no transmission occurred.
[182] *Russell*, 630 N.E.2d at 796.
[183] *Id.* at 796.
[184] 730 ILL. COMP. STAT. ANN. 5/5-4.5-35 (West 2010).
[185] 5/5-4.5-50.
[186] 5/12-16.2(a)(2).
[187] 5/12-6.2(3)(d).

years in prison[188] and a $25,000 fine.[189] A verbal offer to donate blood, fluids, organs, or other tissues may be sufficient for prosecution.

HIV-positive persons can be prosecuted and jailed for sharing dirty syringes with others.

Criminal liability, including imprisonment, may result from sharing or exchanging needles and other drug paraphernalia. Specifically, it is a Class 2 felony, punishable by three to seven years in prison[190] and a $25,000 fine,[191] for an HIV-positive person aware of her/his HIV-positive status to dispense, deliver, exchange, sell, or transfer in any other way to another person any non-sterile "intravenous or intramuscular paraphernalia."[192] This includes syringes, or "any equipment, product, or material of *any* kind which is peculiar to and marketed for use in injecting a substance into the human body."[193]

HIV-positive persons in Illinois are prohibited from selling, sharing, or exchanging, or otherwise transferring to any other person unsterilized needles or any other unsterilized items used to inject substances into the human body. Simply giving someone a dirty syringe is sufficient for a conviction; neither the intent to transmit HIV nor actual transmission is required.

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, it should not be used as a substitute for legal advice.

[188] 5/5-4.5-40(a).
[189] 5/5-4.5-50.
[190] 5/5-4.5-35.
[191] 5/5-4.5-50.
[192] 5/12-6.2(3).
[193] 5/12-6.2(3)(b).

Indiana Statute(s) that Allow for Criminal Prosecution based on HIV Status:

IND. CODE ANN. §§ 16-41-7-1, 35-42-1-9

Carriers' duty to warn persons at risk/Failure of carriers of dangerous communicable diseases to warn persons at risk

People who know of their HIV status have a duty to warn or cause to be warned by a third party person at risk of the following: the carrier's disease status and the need to seek health care, such as counseling and testing. This statute applies to past and present needle sharing and sexual activity that has been epidemiologically demonstrated to transmit HIV. A person who recklessly violates or fails to comply with this law commits a Class B misdemeanor. A person who knowingly or intentionally violates this state statute commits a Class D felony.

IND. CODE § 35-42-2-6(E)

Battery by body waste (on a law enforcement officer)

A person who knowingly or intentionally in a rude, insolent, or angry manner places (or coerces another to place) blood or another body fluid or waste on a law enforcement or corrections officer, firefighter, or first responder (identified as such and engaged in performance of official duties) commits a Class D Felony. If the person knew or recklessly failed to know that the blood, bodily fluid or waste was infected with HIV, it is a Class C felony. If the person knew or recklessly failed to know that the blood, bodily fluid, or waste was infected with HIV and the offense results in transmission of HIV, it is a Class A felony.

IND. CODE § 35-42-2-6(F)

Battery by body waste (on another person, non-law enforcement officer)

A person who knowingly or intentionally in a rude, insolent, or angry manner places human blood, semen, urine or fecal waste on another person commits a Class A misdemeanor. If the person knew or recklessly failed to know that the blood, semen, urine, or fecal waste was infected with HIV, it is a Class D felony. If the person knew or recklessly failed to know that the blood, semen, urine, or fecal waste was infected with HIV and the offense results in transmission of HIV, it is a Class B felony.

IND. CODE § 35-45-16-2(A) & (B)

Malicious mischief (touching)

A person who recklessly, knowingly, or intentionally places human blood, semen, urine, or fecal waste in a location with the intent that another person will involuntarily touch it commits malicious mischief, a Class B misdemeanor. If the person knew or recklessly failed to know that the blood, urine, or waste was infected with HIV, it is a Class D felony. If the person knew or recklessly failed to know that the waste was infected with HIV and the offense results in the transmission of HIV to the other person, it is a Class B felony.

IND. CODE § 35-45-16-2(D)

Malicious mischief (ingesting)

A person who recklessly, knowingly, or intentionally places human blood, body fluid, or fecal waste in a location with the intent that another person will ingest it commits malicious mischief with food, a Class A misdemeanor. If the person knew or recklessly failed to know that the blood, fluid, or waste was infected with HIV, it is a Class D felony. If the person knew or recklessly failed to know that the blood, fluid, or waste was infected with HIV and the offense results in the transmission of HIV to the other person, it is a Class B felony.

IND. CODE § 16-41-14-17

Donation, sale, or transfer of HIV-infected semen

A person who, for the purpose of artificial insemination, recklessly, knowingly, or intentionally donates, sells, or transfers semen that contains HIV antibodies commits a Class C felony. The offense is a Class A felony if the offense results in the transmission of the virus to another person (this does not apply to a person who transfers for research purposes semen that contains HIV antibodies).

IND. CODE § 35-42-1-7

Transferring contaminated bodily fluids

A person who recklessly, knowingly, or intentionally donates, sells, or transfers blood, a blood component, or semen for artificial insemination that contains HIV commits a Class C felony, but if it results in the transmission of HIV it is a Class A felony (this does not apply to person who, for reasons of privacy, donates blood to a blood center after the person has notified the blood center that the blood must be disposed of or who transfers HIV-positive body fluids for research purposes).

IND. CODE. § 35-50-2-4 - 7

Penalties (all include the possibility of a $10,000 fine)
Class A felony: twenty – fifty years imprisonment
Class B felony: six – twenty years imprisonment
Class C felony: two – eight years imprisonment
Class D felony: six months – three years imprisonment

IND. CODE. 35-50-3-3

Class B misdemeanor: no more that 180 days imprisonment and a $1000 fine.

HIV-positive persons can face felony charges for failing to disclose their HIV status to their sexual and needle-sharing partners.

Indiana's "duty to warn" statute requires that HIV-positive persons disclose their status to past, present, and future sexual or needle-sharing partners that have or will engage in activities that have been "demonstrated epidemiologically to transmit" HIV.[194] Such activities include sharing non-sterile needles and engaging in oral, anal, and penile-vaginal sex.[195] It is a Class D felony for a person who knowingly or intentionally fails to disclose her/his HIV status, punishable by up to three years imprisonment and the possibility of a $10,000 fine.

Neither the intent to transmit nor the transmission of HIV is required.

Though disclosing HIV status is the only affirmative defense to prosecution, condom use may potentially be a successful defense. Condoms, when used consistently and correctly, are highly effective in preventing the transmission of HIV in sexual contact "demonstrated epidemiologically to transmit" the virus. Indiana's failure to warn statute does not state whether condom use or the use of other protection is a defense to prosecution, but one case has found that for a successful prosecution, the state must prove that (1) the defendant knew she/he was HIV-positive, (2) engaged in *unprotected* sex, and (3) failed to disclose her/his HIV status during the sexual conduct.[196] Other cases that have been prosecuted under the failure to warn statute have typically involved HIV-positive persons who engaged in unprotected sex with their partners.[197] Though there is limited case law on whether condom use provides a successful defense, the application of the statute appears to be limited to cases where no condom or other form of protection was used.

[194] IND. CODE. § 16-41-7-1 (b)-(c) (2006).
[195] Johnson v. State, 785 N.E.2d 1134 (Ind. Ct. App. 2003).
[196] Johnson, 785 N.E.2d at 1145 n.1.
[197] *See* Sophia Voravong, *Teen Charged in Suspected HIV Lie*, JOURNAL & COURIER, June 10, 2010 (page unavailable); Ruth Anne Krause, *Gary Slaying Suspect has HIV, Cops Say*, MORRILLVILLE POST TRIBUNAL, Nov. 5, 1999, at 4; *AIDS Victim Charged for Having Unprotected Sex*, FORT-WAYNE SENTINEL, Sept. 11, 1998, at 5A.

Other cases and prosecutions in Indiana of HIV-positive persons failing to warn their partners include:

- In June 2010, a 19-year-old woman was charged with failing to disclose her HIV status to her sexual partner, a 22-year-old man that she had met on the social networking site, MySpace.[198] The two engaged in unprotected sex on numerous occasions.
- In March 2010, a man pleaded guilty to two counts of failing to warn his sexual partners that he was HIV-positive.[199] Following his guilty plea, he was charged with, and pleaded not guilty to, fifteen additional counts of failing to tell his sexual partners about his status.[200]
- A man charged with two counts of failing to disclose his HIV status to his sexual partners was sentenced to three years of probation and a suspended one-and-a- half-year prison sentence.[201]
- A 27-year-old woman was charged with failing to warn her sexual partner, with whom she had engaged in unprotected sex, that she was HIV-positive.[202]
- An HIV-positive man was charged with failing to tell his girlfriend that he was HIV-positive.[203] They had been having unprotected sex for four months.
- A 47-year-old, HIV-positive man was charged with failing to warn his sexual partner that he was HIV-positive.[204]

It is a felony for HIV-positive persons to expose others to any bodily fluid, including those not known to transmit HIV.

In Indiana, there are multiple statutes that make it a felony to expose others to blood, semen, saliva, feces, and urine that are "infected with HIV." This law applies to a wide range of acts and bodily fluids that are not means of transmitting HIV, including spitting saliva or throwing urine and feces.

Under Indiana's battery by body waste statutes, it is a Class C felony punishable by up to eight years imprisonment if an HIV-positive person intentionally or knowingly in a rude, insolent, or angry manner places blood, bodily fluid (including tears, saliva, and nasal secretions[205]), or waste on a law enforcement officer, corrections officer, firefighter, or first responder.[206] It is a Class A felony if the exposure results in transmission. The same statute applies when a person intentionally causes another person, who is not a law enforcement officer or first responder, to come in contact with bodily fluids "infected with HIV," but the penalties are less severe.[207] To be prosecuted under this statute, it is only necessary that the bodily fluid make some sort of contact with another's skin or

[198] Sophia Voravong, *Teen Charged in Suspected HIV Lie*, JOURNAL & COURIER, June 10, 2010 (page unavailable).
[199] *Charges Mount in HIV-warning Case*, FORT WAYNE JOURNAL GAZETTE, March 17, 2010, at 3C.
[200] *Man Pleads Not Guilty in AIDS Qarning Case*, INDIANAPOLIS STAR, March 26, 2010, at A24.
[201] Rebecca Green, *Probation Given to Man Who "Hid" HIV*, FORT WAYNE JOURNAL GAZETTE, July 8, 2004, at 2.
[202] *AIDS Victim Charged for Having Unprotected Sex*, *supra* note 213.
[203] Ruth Anne Krause, *Gary Slaying Suspect has HIV, Cops Say*, MORRILLVILLE POST TRIBUNAL, Nov. 5, 1999, at 4.
[204] *Sex Partner Alleges No HIV Wa*rning, FORT WAYNE JOURNAL GAZETTE, Oct. 26, 2007, at 2C.
[205] Newman v. State, 677 N.E.2d 590 (Ind. Ct. App. 1997)(defendant prosecuted under the battery by body waste statute for exposing officers to her tears, saliva, and nasal secretions).
[206] IND. CODE § 35-42-2-6(E) (West 2010).
[207] § 35-42-2-6(F).

clothing.[208]

It is also a felony under the malicious mischief statute to recklessly, knowingly, or intentionally place bodily fluids (including blood, semen, urine, or feces) with the intent that another person might unintentionally touch or eat them.[209] The penalties increase if the person knew the bodily fluids contained HIV or if HIV transmission occurs as a result.

The battery by body waste and malicious mischief statutes provide increased penalties if the bodily fluids in question contain traces of HIV despite the fact that HIV transmission may be impossible under the circumstances. These statutes fail to recognize that urine, feces, and saliva do not transmit HIV, and throwing, spitting, or placing these fluids on another person has never been shown to result in HIV transmission. There have been prosecutions under these statutes involving HIV-positive defendants exposing others to saliva or fecal waste.[210] For example, in *Nash v. State*, the HIV-positive defendant was sentenced to six years imprisonment under the battery by body waste statute for throwing his urine and feces on a nurse in his detention facility.[211] The urine and feces landed on the nurse's shoes and box that she was carrying. Despite the fact that there was no risk of HIV transmission, the court sentenced him under the more severe Class C felony charge for exposing the nurse to bodily fluid "infected with HIV."[212] In these cases, though there is no risk of HIV transmission, HIV-positive persons face increased penalties solely due to their HIV status.

There is only one case on record that challenges the battery by body waste statute. In *Newman v. State*, an HIV-positive sex worker was charged under the Class C felony of purposefully placing her "HIV-infected" body fluids on law enforcement officers who were trying to arrest her. The defendant "swung her head back and forth in an attempt to spray the officers with her tears, saliva, and nasal secretions."[213] The trial judge refused to enter the conviction as a Class C felony and instead convicted her under the lesser included Class D felony offense reasoning that "it's medically impossible to transfer HIV and AIDS through spitting."[214] The defendant was sentenced to three years for battery by body waste. If she had been convicted under the original charges she would have been sentenced to a maximum of eight years imprisonment. Despite the trial court's scientifically sound approach to the facts of the case, the Indiana Court of Appeals disagreed with the trial court's ruling but did not address the sentencing because the State did not raise the issue on appeal.

In a 2002 case, a 37-year-old, HIV-positive homeless man was charged with battery by bodily waste after he allegedly spat on a confinement officer.[215] He was in custody for car-jacking, resisting arrest, and battery. Prior to the spitting incident, he had been charged under the same statute for throwing

[208] Thomas v. State, 749 N.E.2d 1231 (Ind. Ct. App. 2001)(holding that the statute was not ambiguous and affirming conviction when fluid landed on body of person, because legislature intended to penalize the mere "offensive" and "disgusting" nature of such contact).
[209] IND. CODE § 35-45-16-2(A)-(D) (West 2010).
[210] *See* Newman, 677 N.E.2d at 593; *HIV-positive man Charged With Spitting on Officer*, FORT WAYNE SENTINEL, June 11, 2002, at 4A.
[211] 881 N.E.2d 1060 (Ind. Ct. App. 2008).
[212] *Id.* at 1062.
[213] Newman, 677 N.E.2d at 593.
[214] *Id.*
[215] *HIV-positive Man Charged With Spitting on Officer*, FORT WAYNE SENTINEL, June 11, 2002, at 4A.

a cup of urine on another officer.

It is a felony for HIV-positive persons to donate or sell their semen, blood, or plasma.

It is a Class C felony, punishable by two to eight years in prison and a fine of not more than $10,000 fine for a person to donate or sell blood, blood products, or semen that contains HIV.[216] The law does not apply to people who donate semen or blood for research purposes or notify the blood center that the blood or blood component must be discarded and not used for any purpose. It is a Class A felony if the act results in transmission of HIV, which is punishable by twenty to fifty years in prison.

There have been numerous cases of individuals being prosecuted under Indiana's transfer and donating contaminated fluids statutes:

- In 2010, a 39-year-old woman, who tested positive for HIV in 2005, pleaded not guilty to donating her plasma.[217]
- In 2004, a HIV-positive man pleaded guilty and was sentenced to four years imprisonment for selling his plasma.[218]
- A 20-year-old, HIV-positive homeless woman was sentenced to two years of probation for selling her plasma.[219] She received $20 for her donation and testified that she was going to use the money to feed herself and her baby.
- A 46-year-old, HIV-positive man was sentenced to two years imprisonment for selling his blood at a blood plasma donation site.[220]
- In 2003, five HIV-positive persons were charged with multiple counts of transferring contaminated fluids for selling their plasma.[221]

HIV-positive individuals have also been charged under general criminal laws.[222]

In *State v. Haines*[223], the HIV-positive defendant attempted suicide by slashing his wrists, but was interrupted by police and emergency medical technicians. When the police and emergency team

[216] IND. CODE §§ 35-42-1-7, 16-41-14-17 (West 2010).
[217] *Tainted Plasma: Woman Pleads Not Guilty to Donating Tainted Plasma*, FOX59.COM, Mar. 9, 2010, http://www.fox59.com/news/wxin-tainted-plasma-030910,0,2095819.story.
[218] *Man Sentenced in Sale of HIV-tainted Plasma*, INDIANAPOLIS STAR, June 26, 2004, at B2.
[219] *Woman Given Probation for Selling Tainted Plasma*, INDIANAPOLIS STAR, Nov. 6, 2003, at B1.
[220] *Sale of Tainted Blood Nets HIV-positive Man 2 Years*, MERRILLVILLE POST TRIBUNE, April 21, 2007, (A5).
[221] *Five with HIV Accused of Selling Plasma*, INDIANAPOLIS STAR, July 18, 2003, at A1.
[222] In *White v. State*, 647 N.E.2d 684 (Ind. Ct. App. 1995), the court found that HIV could not be considered an aggravating factor during the sentencing of a crime, in this case child molestation, where the record contains no evidence that the defendant was HIV-positive, knew he was HIV-positive, or had received risk counseling.
[223] 545 N.E.2d 834 (Ind. Ct. App. 1989). It should be noted that Indiana's battery by body waste statute was adopted after this case.

arrived, Haines began yelling at them not to come closer or else he would infect them with HIV. He began to scratch, bite, spit at, and throw blood at the officers. Haines was convicted of three counts of attempted murder, but the trial judge vacated the conviction because the state did not prove that HIV could be spread by the defendant's conduct.

On appeal, the court reinstated the attempted murder conviction because the defendant was HIV-positive, knew of his status, and intended to infect others with HIV by spitting, biting, scratching, and throwing blood. The court likened the defendant's actions as "biological warfare […] akin to a sinking ship firing on his rescuers"[224] and found that, even if the conduct in question couldn't result in HIV infection, the defendant still believed that his conduct could result in HIV transmission.

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[224] *Id.* at 838.

Iowa Statute(s) that Allow for Criminal Prosecution based on HIV Status:

IOWA CODE § 709C.1

Criminal transmission of Human Immunodeficiency Virus.

1. A person commits criminal transmission of the human immunodeficiency virus if the person, knowing that the person's human immunodeficiency virus status is positive, does any of the following:
    a. Engages in intimate contact with another person.
    b. Transfers, donates, or provides the person's blood, tissue, semen, organs, or other potentially infectious bodily fluids for transfusion, transplantation, insemination, or other administration to another person.
    c. Dispenses, delivers, exchanges, sells, or in any other way transfers to another person any nonsterile intravenous or intramuscular drug paraphernalia previously used by the person infected with the human immunodeficiency virus.

2. For the purposes of this section:
    a. *"Human immunodeficiency virus"* means the human immunodeficiency virus identified as the causative agent of acquired immune deficiency syndrome.
    b. *"Intimate contact"* means the intentional exposure of the body of one person to a bodily fluid of another person in a manner that could result in the transmission of the human immunodeficiency virus.
    c. *"Intravenous or intramuscular drug paraphernalia"* means any equipment, product, or material of any kind which is peculiar to and marketed for use in injecting a substance into or withdrawing a bodily fluid from the human body.

3. Criminal transmission of the human immunodeficiency virus is a class "B" felony.

4. This section shall not be construed to require that an infection with the human immunodeficiency virus has occurred for a person to have committed criminal transmission of the human immunodeficiency virus.

5. It is an affirmative defense that the person exposed to the human immunodeficiency virus knew that the infected person had a positive human immunodeficiency virus status at the time of the action of exposure, knew that the action of exposure could result in transmission of the human immunodeficiency virus, and consented to the action of exposure with that knowledge.

IOWA CODE § 902.9

Maximum sentence for felons.

The maximum sentence for any person convicted of a felony shall be that prescribed by statute or, if not prescribed by statute, if other than a class "A" felony shall be determined as follows:

1. A class "B" felon shall be confined for no more than twenty-five years.

IOWA CODE § 692A.102

Sex offense classifications.

1. For purposes of this chapter, all individuals required to register shall be classified as a tier I, tier II, or tier III offender. For purposes of this chapter, sex offenses are classified into the following tiers:
   c. Tier III offenses include a conviction for the following sex offenses:
      22. Criminal transmission of human immunodeficiency virus in violation of section 709C, subsection 1, paragraph "a".

Failure to disclose HIV status before sexual activities may result in prosecution.

Individuals with HIV in Iowa should be aware that a broad range of both sexual and non-sexual activities may result in prosecution and imprisonment under the state's HIV criminal transmission statute. Also, though Iowa's statute is called "Criminal transmission of Human Immunodeficiency Virus," neither the intent to transmit HIV nor the actual transmission of HIV is required for prosecution.

In Iowa, it is a Class B felony, punishable by up to 25 years in prison,[225] for a person who knows she/he is HIV-positive to engage in intimate contact with another.[226] Sex offender registration is also required.[227]

[225] IOWA CODE § 902.9(2) (2011).
[226] *Id.* § 709C.1(1)(a) (2011).
[227] *Id.* § 692A.102(1)(c)(22) (2011).

"Intimate contact" is defined as the intentional exposure of the body of one person to a bodily fluid of another person in a manner that *could* result in the transmission of HIV.[228] The use of condoms or other protection during sexual activity is not a defense to prosecution without prior disclosure of one's HIV status.

In *State v. Keene*, an HIV-positive man was charged with criminal transmission of HIV after engaging in unprotected sexual intercourse with a female partner without first disclosing his HIV status.[229] After pleading guilty, the defendant received the maximum sentence of 25 years in prison. The defendant argued on appeal that Iowa's criminal transmission laws were unconstitutionally vague as applied to his case. The statutory language defining intimate contact ("the intentional exposure of the body of one person to a bodily fluid of another person in a manner that could result in the transmission of the human immunodeficiency virus"[230]) was at issue; specifically, the defendant argued that the term "could not" was not defined in the statute.[231] The Supreme Court of Iowa disagreed, holding that prosecution under Iowa's criminal transmission law was lawful as long as HIV transmission was *possible* and stated that "any reasonably intelligent person is aware it is possible to transmit HIV during sexual intercourse, especially when it is unprotected."[232] It cited several cases in which states with HIV criminal transmission statutes analogous to Iowa's statute rejected similar constitutional challenges.[233]

In *Keene*, the Supreme Court of Iowa also clarified the types of intimate contact that may result in prosecution, recognizing that "HIV may be transmitted through contact with an infected individual's blood, semen or vaginal fluid, and that sexual intercourse is one of the most common methods of passing [HIV]."[234]

Following *Keene*, *State v. Stevens* held that an HIV-positive individual may be prosecuted under Iowa's criminal transmission statute if she/he engages in oral sex.[235] In *Stevens*, a 33-year-old, HIV-positive man was sentenced to 25 years in prison after he engaged in oral sex with a 15-year-old boy and ejaculated in the boy's mouth. He also received a 10-year sentence for sexual abuse of a child. Notably, the court in *Stevens* interpreted the definition of "sexual intercourse" in *Keene* to include oral sex, holding that "oral sex is a well-recognized means of transmission of the HIV."[236]

Even though Iowa's definition of intimate contact requires exposure to bodily fluids, conviction under the HIV criminal transmission statute may occur without proof of ejaculation. In *Keene,* the Supreme Court of Iowa determined that the question of whether the defendant ejaculated during intercourse was irrelevant so long as the defendant exposed another to his bodily fluids.[237] In *State v. Musser*, an HIV-positive man was convicted under the HIV criminal transmission statute and sentenced to 25 years in prison after engaging in unprotected sexual intercourse several times with a

[228] *Id.* § 709C.1(2)(b) (2011).
[229] State v. Keene, 629 N.W.2d 360, 362 (Iowa 2001).
[230] IOWA CODE § 709C.1(2)(b).
[231] State v. Keene, 629 N.W.2d 360, 365 (Iowa 2001).
[232] State v. Keene, 629 N.W.2d 360, 365 (Iowa 2001).
[233] State v. Keene, 629 N.W.2d 360, 366 (Iowa 2001).
[234] State v. Keene, 629 N.W.2d 360, 363 (Iowa 2001).
[235] State v. Stevens, 719 N.W.2d 547 (Iowa 2006).
[236] State v. Stevens, 719 N.W.2d 547, 551 (Iowa 2006).
[237] State v. Keene, 629 N.W.2d 360, 366 (Iowa 2001).

female partner without disclosing his status.[238] The defendant argued on appeal that he did not expose the woman to bodily fluids because he did not ejaculate. Citing testimony by the county public health director that HIV transmission was possible during sexual intercourse without ejaculation, the Supreme Court of Iowa affirmed the defendant's conviction.

The defendant in *Musser* filed a separate appeal challenging the constitutionality of Iowa's HIV criminal transmission statute.[239] He claimed the statute violated his First Amendment rights, was vague and overbroad, and infringed on his right of privacy. The Supreme Court of Iowa rejected all three arguments, and found that the statute was the least restrictive way to further the compelling state interest in limiting the spread of HIV.

An individual prosecuted under Iowa's HIV criminal transmission statute may have a defense if she/he can prove that the person exposed to HIV (1) knew that the defendant was HIV-positive, (2) was aware that the exposure could result in the transmission of HIV, and (3) consented to HIV exposure with knowledge of these risks.[240] Proving disclosure of one's HIV status is difficult since evidence is often limited to parties' testimony. In *Musser*, for example, the defendant testified that his partner knew of his HIV-positive status before they engaged in unprotected sexual intercourse, but the jury chose to believe his partner, the complainant, who claimed otherwise.[241]

Conviction under Iowa's HIV criminal transmission statute requires sex offender registration.

All persons convicted under Iowa's HIV criminal transmission statute are required to register as a tier III sex offender.[242] Tier III is reserved for those offenders convicted of the most severe sex offenses. Tier III offenders must verify residence, employment, and other information more frequently than other offenders, and must wait longer to apply for modification of her/his sex offender registration requirements.[243]

In April 2009, a 34-year old, HIV-positive man was charged with criminal transmission of HIV after failing to disclose his status to a one-time male sexual partner.[244] After pleading guilty, the defendant was sentenced to 25 years in prison and lifetime registration as a sex offender. As a sex offender, the defendant was barred from being around minors without their parents' supervision, and was subject to GPS ankle bracelet monitoring, curfews, psychological and polygraph tests, and random, unannounced searches of his computer to ensure he was not accessing social media websites or pornography.[245] The defendant's sentence was later reduced to five years of probation, but his sex offender registration requirements remained intact.

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[238] State v. Musser, 721 N.W.2d 758, 759-62 (Iowa 2006).
[239] State v. Musser, 721 N.W.2d 734 (Iowa 2006).
[240] IOWA CODE § 709C.1(5) (2011).
[241] State v. Musser, 721 N.W.2d 758, 760 (Iowa 2006).
[242] IOWA CODE, § 692A.102 (2011).
[243] *Id.* § 692A.108, § 692A.128.
[244] Arthur Breur, *Nick Rhoades 25-year Sentence Cut Short, But He's Hardly a Free Man*, ACCESSLINE IOWA, Sept. 14, 2009, http://accesslineiowa.com/index.php?option=com_content&view=article&id=151:nick-rhoades-25-year-sentence-cut-short-but-hes-hardly-a-free-man&catid=92:editorials&Itemid=59.
[245] HIV IS NOT A CRIME (Sean Strub 2011), http://www.youtube.com/watch?v=iB-6blJjbjc.

HIV-positive persons are prohibited from donating or providing blood, human tissue, semen, organs, or bodily fluids.

In Iowa, it is a Class B felony, punishable by up to 25 years in prison,[246] for an HIV-positive person who is aware of her/his HIV status to donate, transfer, or provide blood, tissue, semen, organs, or "other potentially infectious bodily fluids" for transfusion, transplant, insemination, or administration to another.[247] Neither the intent to transmit HIV nor actual transmission is required for prosecution.[248]

HIV-positive persons are prohibited from sharing needles and syringes with others.

Iowa specifically targets HIV-positive drug users who share or exchange their needles and syringes. Specifically, it is a Class B felony, punishable by up to 25 years in prison,[249] for an HIV-positive person aware of his/her HIV-positive status to dispense, deliver, exchange, sell, or transfer in any other way to another any non-sterile "intravenous or intramuscular paraphernalia" that she/he has previously used.[250]

Such paraphernalia includes needles, syringes, or any other "equipment, product, or material of any kind which is peculiar to and marketed for use in injecting a substance into the human body."[251] Neither the intent to transmit HIV nor actual transmission is required.[252]

An HIV-positive individual prosecuted under this statute may have a defense if she/he can prove that the individual exposed to unsterilized drug paraphernalia (1) was aware that she/he was HIV-positive, (2) knew that using unsterilized drug paraphernalia could result in HIV infection, and (3) consented to HIV exposure knowing of this risk.[253]

[246] IOWA CODE § 902.9(2) (2011).
[247] *Id.* § 709C.1(1)(b) (2011).
[248] *Id.* § 709C.1(4) (2011).
[249] *Id.* § 902.9(2) (2011).
[250] *Id.* § 709C.1(1)(c) (2011).
[251] *Id.* § 709C.1(2)(c) (2011).
[252] IOWA CODE § 709C.1(4) (2011).
[253] *Id.* § 709C.1(5) (2011).

Kansas Statute(s) that Allow for Criminal Prosecution based on HIV Status:

2010 Kan. Sess. Laws Ch. 136 (H.B. No. 2668, New Sec. 59)*

Severity Level 7, Person Felony: intentional exposure to life threatening disease

It is unlawful for a person who knows oneself to be infected with a life threatening communicable disease, to:

1. Engage in sexual intercourse or sodomy with another individual with the intent to expose that individual to that life threatening communicable disease;

2. Sell or donate one's own blood, blood products, semen, tissue, organs, or other body fluids with the intent to expose the recipient to a life threatening communicable disease; or

3. Share with another individual a hypodermic needle, syringe, or both, for the introduction of drugs or any other substance into, or for the withdrawal of blood or body fluids from, the other individual's body with the intent to expose another person to a life threatening communicable disease.

Violation of this section is a severity level 7, person felony.**

"Sexual intercourse" shall not include penetration by any object other than the male sex organ.

"Sodomy" shall not include penetration of the anal opening by any object other than the male sex organ.

* Re-codification of KAN. CRIM. CODE. ANN. § 21-3435 (West 2010).
** *See* Kansas Sentencing Guidelines, available at http://www.sedgwickcounty.org/da/sentencing_grid.html.

Engaging in penile-vaginal sex or anal sex with the specific intent to transmit HIV is a felony.

It is a severity level 7, person felony punishable by up to twenty-six months in prison[254] for a person who knows that she/he is infected with a "life threatening communicable disease" to (1) engage in

[254] *See* KAN. SENTENCING GUIDELINES app. B (2009), *available at* http://www.accesskansas.org/ksc/2009desk.shtml.

sexual intercourse or sodomy (2) with the intent to expose another to the disease.[255] Although "life threatening communicable disease" is not defined, HIV appears to be included, as at least one HIV-positive person in Kansas has been charged for HIV exposure under this statute.[256]

Under Kansas's exposure laws, "sexual intercourse" only includes penetration by the penis.[257] Because even the slightest insertion of the penis into the vagina can be considered "penetration," ejaculation or the emission of bodily fluids are not required for prosecution.[258] Under the terms of this exposure statute, "sodomy" is limited to anal penetration by nothing other than the penis.[259] Oral sex is not prosecuted under this statute.

In the 2009 case *State v. Richardson*,[260] an HIV-positive man appealed his conviction of two counts of exposing another to a life-threatening disease. He was convicted after having sex with two women at a time when his viral load measured as undetectable. At trial and on appeal, the defendant argued that Kansas' communicable disease exposure law fails to give adequate notice as to what constitutes a "life threatening" disease, "exposure" to HIV, and what viral load would be sufficient for a criminal exposure to HIV. The Supreme Court of Kansas rejected these arguments, stating that the law does not criminalize communicable disease exposure *per se*, but rather sexual intercourse or sodomy with the *intent* to expose another to a communicable disease. It added, "One need not ruminate on exactly how the act must be performed to meet the legal definition of 'expose' or even know that a transmittal of the disease is possible."[261]

Importantly, the *Richardson* court also ruled that Kansas' communicable disease exposure statute required that a defendant have the *specific intent* to expose sexual partners to HIV. It was not sufficient if a defendant had the *general intent* to engage in sexual intercourse while HIV-positive. In doing so, the court rejected the prosecution's argument that Kansas' communicable disease exposure law criminalized *any* act of sexual intercourse or sodomy by an HIV-positive person, even if a condom was used. The prosecution went as far as to suggest that complete abstinence from sex is the only way to avoid exposing others to a risk of HIV. The Kansas Supreme Court disagreed and vacated the man's conviction after the state failed to prove that his specific intent was to expose his sexual partners to HIV.

The court found that the elements of specific intent could include an analysis of whether the HIV-positive person disclosed her/his HIV status, used a condom during sexual acts, or specifically denied having HIV or sexually transmitted diseases.[262] Without taking into account such elements the prosecution cannot prove specific intent.

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[255] 2010 Kan. Sess. Laws Ch. 136 (H.B. No. 2668) (*See* New Sec. 59(a)(1), repealing and re-codifying KAN. CRIM. CODE. ANN. § 21-3435(a)(1) (West 2010)).
[256] State v. Richardson, 209 P.3d 696 (Kan. 2009).
[257] 2010 Kan. Sess. Laws Ch. 136 (H.B. No. 2668) (*See* New Sec. 59(c)(1), repealing and re-codifying KAN. CRIM. CODE. ANN. § 21-3435(b) (West 2010)).
[258] *See, e.g.* KAN. CRIM. CODE ANN. § 21-3501(1) (defining "sexual intercourse" as any act of penetration, however slight).
[259] 2010 Kan. Sess. Laws Ch. 136 (H.B. No. 2668) (*See* New Sec. 59(c)(2), repealing and re-codifying KAN. CRIM. CODE. ANN. § 21-3435(b)).
[260] 209 P.3d 696 (Kan. 2009).
[261] *Id.*
[262] *Id.* at 704.

HIV-positive persons are prohibited from donating blood, blood products, semen, human tissue, organs, or body fluids.

In Kansas, it is a severity level 7, person felony, punishable by up to twenty-six months in prison,[263] for a person who knows that she/he is infected with a "life threatening communicable disease" to (1) sell or donate blood, blood products (plasma, platelets, etc.), semen, tissue, organs, or other body fluids (2) with the intent to expose the recipient to the disease.[264]

HIV-positive persons are prohibited from sharing needles or syringes.

In Kansas, it is also a severity level 7, person felony, punishable by up to twenty-six months in prison[265] for a person who knows that she/he is infected with a "life threatening communicable disease" to share a hypodermic needle and/or syringe with another for (1) the introduction of drugs or any other substance, or (2) the withdrawal of body fluids from that person's body.[266] Intent to expose another to HIV is also required for conviction.

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, should not be used as a substitute for legal advice.

[263] *See* Kansas Sentencing Guidelines, http://www.sedgwickcounty.org/da/sentencing_grid.html.
[264] 2010 Kan. Sess. Laws Ch. 136 (H.B. No. 2668) (*See* New Sec. 59(a)(2), repealing and re-codifying KAN. CRIM. CODE. ANN. § 21-3435(a)(2) (West 2010)).
[265] *See* Kansas Sentencing Guidelines, http://www.sedgwickcounty.org/da/sentencing_grid.html.
[266] 2010 Kan. Sess. Laws Ch. 136 (H.B. No. 2668) (*See* New Sec. 59(a)(3), repealing and re-codifying KAN. CRIM. CODE. ANN. § 21-3435(a)(3) (West 2010)).

Kentucky Statute(s) that Allow for Criminal Prosecution based on HIV Status:

KY. REV. STAT. ANN. § 311.990(24)(B)

Donation of human organs, skin, and other tissues

Any person infected with HIV knowing that she/he is infected and having been informed of the possibility of communicating the infection by donating human organs, skin, or other human tissues who donates organs, ski,n or other human tissue is guilty of a Class D felony.

KY. REV. STAT. ANN. §§ 529.090(3)-(4)

Prostitution with knowledge of HIV-positive status

Any person who commits, offers, or agrees to commit prostitution by engaging in sexual activity in a manner likely to transmit the human immunodeficiency virus and who, prior to the commission of the crime, had tested positive for human immunodeficiency virus and knew or had been informed that she/he had tested positive for human immunodeficiency virus and that she/he could possibly communicate the disease to another person through sexual activity is guilty of a Class D felony.

A person may be convicted and sentenced separately for a violation of this subsection and for the underlying crime of prostitution.

KY. REV. STAT. ANN. § 532.060(2)(D)

Sentence of imprisonment for felony

For a Class D felony, not less than one year nor more than five years.

KY. REV. STAT. ANN. § 534.030(1)

Fines for felonies

Except as otherwise provided for an offense defined outside this code, a person who has been convicted of any felony shall, in addition to any other punishment imposed upon her/him, be sentenced to pay a fine in an amount not less $1,000 and not greater than $10,000 or double her/his gain from commission of the offense, whichever is the greater.

HIV-positive persons are prohibited from donating organs, skin, or other human tissues.

It is a Class D felony, punishable by one to five years in prison[267] and a $1,000- $10,000 fine[268] for a person who (1) knows that she/he is HIV-positive and (2) has been informed that she/he may transmit HIV through organ, skin, or tissue donations to provide any such donations.[269] Neither the intent to transmit HIV nor infection of another are required for conviction, and prosecution is possible regardless of whether an HIV-positive donor is paid.

Engaging in prostitution or solicitation while HIV-positive is a felony.

It is a Class D felony, punishable by one to five years in prison[270] and a $1,000- $10,000 fine,[271] if an HIV person (1) knows or has been informed that she/he has tested positive for HIV, (2) is aware or has been informed that HIV can be transmitted through sexual activities, and (3) commits, offers, or agrees to commit prostitution by engaging in sexual activity "in a manner likely to transmit HIV."[272] Neither the intent to transmit HIV nor actual transmission is required for conviction. Disclosing HIV status to sexual partners nor the use of protection are defenses to prosecution.

Kentucky's prostitution laws penalize individuals for being HIV-positive, regardless of whether they engage or plan to engage in activities that expose others to a significant risk or any risk of HIV infection. Under the terms of this statute, "prostitution" is defined as engaging, agreeing to engage, or offering to engage in "sexual conduct" in return for a fee.[273] "Sexual conduct" is defined as "sexual intercourse or any act of sexual gratification involving the sex organs."[274]

It is also a Class D felony, punishable by one to five years in prison[275] and a $1,000- $10,000 fine,[276] if an HIV-positive person (1) knows or has been informed that she/has tested positive for HIV, (2) is aware or has been informed that HIV can be transmitted through sexual activities, and (3) procures another to commit prostitution.[277] Procurement laws often punish "pimping" as opposed to solicitation of prostitution, but this provision is presumably a solicitation law targeting HIV-positive persons who seek out or hire sex workers.

HIV-positive individuals have been prosecuted under Kentucky's general criminal laws.

Kentucky has used general criminal laws to prosecute HIV-positive individuals for transmitting HIV, failing to disclose HIV status to sexual partners, or otherwise exposing others to HIV infection. These prosecutions often disregard whether HIV-positive defendants actually exposed

[267] KY. REV. STAT. ANN. § 532.060(2)(d) (West 2010).
[268] § 534.030(1).
[269] § 311.990(24)(b).
[270] § 532.060(2)(d).
[271] § 534.030(1).
[272] § 529.090(3).
[273] § 529.020(1).
[274] § 529.010(9).
[275] § 532.060(2)(d).
[276] § 534.030(1).
[277] § 529.090(4).

others to a significant risk of HIV infection or if there was even a scientific possibility that HIV could be transmitted.

Kentucky's "wanton endangerment" law is one example of a general criminal law that has been used to prosecute HIV-positive persons for alleged HIV exposure. In Kentucky, the crime of first-degree wanton endangerment, punishable by one to five years in prison[278] and a $1,000- $10,000 fine,[279] requires than an individual wantonly engage in "conduct which creates a substantial danger of death or serious physical injury to another person."[280]

In *Hancock v. Commonwealth*,[281] Kentucky's first case determining whether HIV exposure could be prosecuted under the state's wanton endangerment laws, an HIV-positive man had a two-year sexual relationship with a woman, allegedly without disclosing his HIV-positive status. Although the man testified that his partner knew he was HIV-positive, he later pleaded guilty to second-degree wanton endangerment. He received a 120-day suspended sentence plus one year of probation.

On appeal of the initial indictment, the Court of Appeals of Kentucky rejected the argument that Kentucky's wanton endangerment statute could not apply to HIV exposure, finding the charge valid on its face "in light of the deadly nature of HIV."[282] The court also found that the defendant's contention that his partner knew of his HIV-positive status had no bearing on the issue of whether his charges should have been dismissed. That was an issue of fact the man would have to raise before the jury as a defense to prosecution.

Neither the intent to transmit HIV nor actual transmission is required for prosecution for wanton endangerment. Because the defendant in *Hancock* pleaded guilty, there is no jurisprudence on how condoms or other protection during sexual intercourse or evidence of a defendant's low viral load would factor into a prosecution for wanton endangerment, although it certainly could be argued that those factors reduce the risk to below that of the statutory "substantial danger" standard.

In another case, in 2008 a 29-year old, HIV-positive woman was charged with attempted murder when she allegedly bit a store clerk on the chest during a robbery, and then shouted that she had AIDS.[283] She later pleaded guilty to first-degree robbery and first-degree wanton endangerment and was sentenced to twelve years imprisonment. The store clerk tested negative for HIV. Two years of her prison sentence arose from the endangerment charge based solely on her HIV-positive status, despite the fact the CDC has concluded that there is only a "remote" possibility that HIV could be transmitted through a bite and such transmission would have to involve various aggravating factors including "severe trauma, extensive tissue damage, and the presence of blood."[284]

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[278] § 532.060(2)(d).
[279] § 534.030(1).
[280] § 508.060(1).
[281] 998 S.W.2d 486, 497 (Ky. Ct. App. 1998).
[282] *Id.* at 498.
[283] *HIV-Positive Robber Receives 12-year Prison Sentence*, WKYTV.COM, April 8, 2008, *available at* http://www.wkyt.com/home/headlines/17382524.html; Greg Kocher, *Accused Robber, Biter has HIV*, LEXINGTON HERALD-LEADER, Sept. 13, 2007, at D1.
[284] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted through a human bite?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).

Another case in Kentucky involved HIV-positive status as a factor during sentencing for sexual assault. In *Torrence v. Commonwealth*,[285] an HIV-positive man found guilty of first-degree rape and sodomy argued that it would violate his due process rights to introduce evidence of his HIV status during the sentencing phase of his trial. At trial, the assault complainant testified that she learned of the defendant's HIV-positive status following the rape, took medication to prevent infection, and suffered emotional damage due to her fears of HIV infection and alleged feelings of alienation from her family. The Supreme Court of Kentucky found no error in admitting this evidence during sentencing, as it directly related to physical and psychological harm the victim suffered, and the impact of a crime on a victim is consideration during sentencing. The court also noted that the defendant's HIV-positive status magnified his victim's suffering beyond that of a "typical" rape victim.

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[285] 269 S.W.3d 842 (Ky. 2008).

Louisiana Statute(s)[286] that Allow for Criminal Prosecution based on HIV Status:

LA. REV. STAT. ANN. § 14:43.5

Intentional exposure to AIDS virus

A. No person shall intentionally expose another to any acquired immunodeficiency syndrome (AIDS) virus through sexual contact without the knowing and lawful consent of the victim.

B. No person shall intentionally expose another to any acquired immunodeficiency syndrome (AIDS) virus through any means or contact without the knowing and lawful consent of the victim.

C. No person shall intentionally expose a police officer to any AIDS virus through any means or contact without the knowing and lawful consent of the police officer when the offender has reasonable grounds to believe the victim is a police officer acting in the performance of his duty.

"Means or contact" is defined as spitting, biting, stabbing with an AIDS contaminated object, or throwing of blood or other bodily substances.

"Police officer" includes a commissioned police officer, sheriff, deputy sheriff, marshal, deputy marshal, correctional officer, constable, wildlife enforcement agent, and probation and parole officer.

An individual convicted of intentional exposure to AIDS virus shall be fined not more than $5,000, imprisoned with or without hard labor for not more than ten years, or both. Whoever commits the crime against a police officer shall be fined not more than $6,000, imprisoned with or without hard labor for not more than eleven years, or both.

[286] Under the public health laws of Louisiana, it is unlawful for any person to "inoculate or infect another person in any manner with a venereal disease or to do any act which will expose another to inoculation or infection with a venereal disease." LA. REV. STAT. ANN. § 40:1062 (1918); *See also* LA. REV. STAT. ANN. § 40:1068 (1918); Meany v. Meany, 639 So.2d 229 (La. 1994) (imposing a civil duty on those infected with a venereal disease to either abstain from sex or warn sexual partners). A venereal disease is defined as "syphilis, gonorrhea, chancroid, or any other infectious disease primarily transmitted from one person to another by means of a sexual act." LA. REV. STAT. ANN § 40:1061 (2007). However, because this law was enacted in 1918, long before the discovery of HIV, and because Louisiana has enacted a separate criminal statute concerning HIV exposure, it is unlikely that this statute will be used to penalize HIV exposure.

Any number of consensual sexual activities may result in prosecution and imprisonment.

It is an unlawful act, punishable by up ten years in prison and/or a $5,000 fine,[287] to expose another to HIV/AIDS through sexual contact.[288] Sex offender registration may also be required.[289] Despite the language in the statute, Louisiana courts have found that neither the intent to transmit HIV[290] nor actual transmission is required.[291]

It is a defense if exposure to HIV was with "knowing and lawful consent."[292] This means that an HIV-positive person will not likely be prosecuted for engaging in consensual sexual intercourse with a partner fully aware of her/his HIV status, as long as that partner is above the age of consent in Louisiana.[293]

However, disclosure of HIV status may be difficult to prove as most evidence is based on the testimony of the parties where it is one person's word against the other's. In *State v. Gamberella*,[294] an HIV-positive man was convicted of HIV exposure despite his testimony that he disclosed his HIV-positive status to his girlfriend and wore condoms during sex. The man's girlfriend, the complainant, testified that after she became pregnant by the defendant after a condom failed, they engaged in unprotected sexual intercourse on multiple occasions. She testified that she didn't know his HIV-positive status during the entire relationship. The defendant was convicted and sentenced to ten years in prison at hard labor.

On appeal, the defendant in *Gamberella* argued that the law failed to define such terms as "expose" and "sexual contact," and therefore could prohibit activities posing no risk of HIV transmission, including kissing. The Court of Appeal of Louisiana rejected these arguments, holding that the statute described prohibited conduct with sufficient particularity. The court reasoned that the term "sexual contact . . . unambiguously [refers to] numerous forms of behavior involving use of the sexual organs of one or more of the participants or involving other forms of physical contact for the purpose of satisfying or gratifying the 'sexual desires' of one of the participants."[295] The preceding phrase, in and of itself, is ambiguous and provides absolutely no clarity as to what types of sexual conduct can be prosecuted under the statute. Under the court's definition, acts that don't involve an exchange of bodily fluids or penetration could be prosecuted. The court's findings also don't provide insight into whether or not the use of condoms or other form of protection would be a defense to prosecution.

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[287] LA. REV. STAT. ANN. § 14:43.5(E)(1) (1993).
[288] § 14:43.5(A).
[289] § 541(24)(2005) (modified with minor changes by 2010 La. Sess. Law Serv. Act. 387 (H.B. 825)).
[290] *See, e.g.,* State v. Roberts, 844 So. 2d 263, 272 (La. Ct. App. 2003) ("La. R.S. 14:43.5 does not require the State to prove that a defendant acted with the specific intent to expose the victim to [HIV] … it requires the State to prove that the defendant intentionally committed an act proscribed by the statute which exposed the victim to [HIV].")
[291] *See, e.g.,* State v. Gamberella, 633 So. 2d 595, 602 (La. Ct. App. 1993) ("By use of the word 'expose' rather than the word 'transmit,' the legislature obviously intended that the element of the offense be the risk of infection, rather than actual transmission of the virus."); accord *Roberts*, 844 So. 2d at 272.
[292] LA. REV. STAT. ANN. § 14:43.5(A)(1993).
[293] *See, e.g.,* LA. REV. STAT. ANN. § 14:80 (2004) (defining "juvenile" as an individual under the age of seventeen for the purpose of "carnal knowledge" laws).
[294] *Gamberella,* 633 So. 2d at 598-60.
[295] *Id.* citing Cheney C. Joseph, Jr., *Developments in the Law 1986-1987: A Faculty Symposium*, 48 LA. L. REV. 257 (1987).

Other cases that have been prosecuted under the statute include:

- In *State v. Serrano*, an HIV-positive man was sentenced to one year in prison at hard labor after he engaged in unprotected sex with his girlfriend without disclosing his HIV status.[296]
- In *State vs. Turner*, an HIV-positive woman received two concurrent five-year prison sentences after she pleaded guilty to engaging in "some sort of sexual contact" with two men.[297] A sentencing court equated the woman's activities to "pointing a gun to [the victims'] head[s] and pulling the trigger."[298]
- In 1999, an HIV-positive woman received four years probation and registered as a sex offender after engaging in unprotected sex with at least two men.[299]
- In 2002, an HIV-positive man was arrested after he allegedly engaged in unprotected sex with a woman without disclosing his HIV status.[300]
- In *State v. Roberts*, an HIV-positive man received ten years in prison at hard labor for exposing his rape victim to HIV.[301] Although a dispute existed as to whether bodily fluids were exchanged, an appeals court found that the defendant's conviction could be sustained on evidence that he anally and vaginally raped his victim.[302]

Spitting, biting, and other exposures to bodily fluids can result in criminal liability.

Louisiana criminalizes several forms of HIV exposure beyond sexual contact that pose no risk of HIV infection, including biting and spitting. It is an unlawful act, punishable by up ten years in prison (with or without hard labor) and/or a $5,000 fine,[303] to expose a person to any AIDS virus through *any* means or contact without the knowing and lawful consent of the person exposed.[304]

If an HIV-positive person (1) exposes a police officer to HIV through "any means or contact," and (2) has reasonable grounds to believe that the person exposed is a police officer, HIV exposure is punishable by up to eleven years in prison (with or without hard labor) and/or a $6,000 fine.[305] This sentence enhancement also applies to correctional officers, parole officers, and several other "police officers," including probation officers, sheriffs, deputy sheriffs, marshals, deputy marshals, constables, and wildlife enforcement agents.[306]

[296] 715 So. 2d 602, 602-03 (La. Ct. App. 1998).
[297] 927 So. 2d 438, 439-41 (La. Ct. App. 2005).
[298] *Turner*, 927 So.2d at 441.
[299] Joe Darby, *Woman Pleads Guilty in HIV Exposure Case,* TIMES-PICAYUNE (New Orleans), Jan. 26, 1999, at B2.
[300] *Metairie Man Arrested on HIV Charge,* TIMES-PICAYUNE (New Orleans), May 25, 2002, at 4-Metro.
[301] *Roberts,* 844 So.2d at 270.
[302] *Id.*
[303] LA. REV. STAT. ANN. § 14:43.5(E)(1)(1993).
[304] § 14:43.5(B).
[305] § 14:43.5(C).
[306] § 14:43.5(D)(2).

Neither the intent to transmit HIV nor actual transmission is required.

Under the terms of this statute, "means or contact" is defined as spitting, biting, stabbing another with an AIDS-contaminated object (e.g., a used needle), or throwing blood or other "bodily substance."[307] Although throwing blood or other "bodily substances" is listed as a criminal offense under the terms of this statute, "bodily substance" is not defined.[308] This statute thus presents the risk that exposure to saliva, urine, sweat, or other "bodily substances" posing no risk of HIV infection may result in criminal prosecution.

In *State v. Roberts,*[309] for example, an HIV-positive defendant was convicted of intentionally exposing a rape victim to HIV after he raped and bit her. On appeal, the defendant argued that the state failed prove that (1) biting a person could expose that person to HIV, (2) the teeth of an HIV-positive man could be "AIDS-contaminated" objects, (3) that his mouth contained saliva, and (4) that his bite broke his victim's skin.[310] The Court of Appeal of Louisiana rejected these arguments because the statute specifically noted biting to be an offense under the statute.[311] The court did not consider that the CDC has long maintained that there exists only a "remote" possibility that HIV could be transmitted through a bite and such transmission would have to involve various aggravating factors including "severe trauma, extensive tissue damage, and the presence of blood."[312]

The CDC has also concluded that spitting alone has never been shown to transmit HIV.[313] Louisiana's statute and its application ignore these scientific findings, leading to prosecutions for behavior that has at best a remote possibility of transmitting HIV.

Attempted murder[314] prosecutions have been used for intentional exposure to HIV.

Individuals with HIV in Louisiana may be prosecuted for HIV exposure under general criminal laws, including attempted murder. In the past, these prosecutions have arisen from the rare and extreme cases where HIV-positive persons attempt to purposefully infect others with the virus. In *State v. Caine*,[315] an HIV-positive man was convicted of attempted second-degree murder after he allegedly

[307] § 14:43.5(D)(1).
[308] § 14:43.5(D)(1).
[309] 844 So. 2d 263, 265-69 (La. Ct. App. 2003).
[310] *Id.* at 270-71.
[311] *Id.* at 271.
[312] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted through a human bite?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).
[313] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV by being spit on by an HIV infected person?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).
[314] In another case involving HIV-infected syringes, a Louisiana doctor received fifty years in prison at hard labor after he was convicted of injecting his ex-lover with HIV and Hepatitis C. The doctor extracted tainted blood from two patients and transferred it to the woman, who believed she was getting an injection of a vitamin supplement. This case was not based on the doctor's HIV status and as such as not reflective of prosecutions against HIV-positive persons. 771 So. 2d 131 (La. Ct. App. 2000) (affirming conviction and sentence), *writ denied,* 798 So. 2d 105 (La. 2001), *cert. denied*, 535 U.S. 905 (2002); *see also* State v. Schmidt, 699 So. 2d 448 (La. Ct. App. 1997) (denying writ application concerning two pre-trail evidentiary rulings regarding admissibility of DNA evidence), *writ denied,* 706 So. 2d 451 (La. 1997); Schmidt v. Hubert, No. 05-2168, 2008 WL 4491467 (W.D. La. Oct. 6, 2008) (denying habeas corpus petition challenging conviction).
[315] 652 So. 2d 611 (La. Ct. App. 1995), *writ denied*, 661 So. 2d 1358 (La. 1995).

stuck a store clerk with a syringe full of clear liquid and said "I'll give you AIDS." The syringe was never recovered, and it is not known whether the clear liquid was contaminated with HIV.[316] However, because the defendant was HIV-positive, pulled a needle out of his pocket, and had "track marks" on his arm suggesting a history of drug use, the Court of Appeal of Louisiana found it likely that the needle was infected with HIV, and affirmed the defendant's sentence of fifty years in prison at hard labor.

HIV-positive status can result in an enhanced sentence upon conviction.

HIV-positive status can be a factor in enhanced sentences for sexual assault. Sentencing courts sometimes see HIV-positive status as a relevant consideration when measuring the impact of a crime on the victim (See, e.g., Kentucky, Utah, Texas).

In *State v. Richmond*,[317] the Court of Appeal of Louisiana rejected an argument from an HIV-positive sex worker that a ten-year sentence for conviction of a crime against nature by soliciting unnatural oral copulation for compensation was excessive. Although the court noted that a ten-year sentence was harsh, the trial judge, who is afforded wide discretion on sentencing, supported the sentence by stating that the woman committed prostitution with knowledge of her HIV-positive status and should, therefore, be punished to the full extent of the law for the danger that she posed to others "who are not ill right now, who can be protected."[318] The trial court compared the woman's actions to imposing a death sentence for others "because of what [she carries] around inside [her] body."[319] The Louisiana Court of Appeal affirmed the defendant's sentence of ten years in prison based on her prior record as a third felony offender. Despite the fact that the defendant did not engage in oral sex, and even if she had there was only a remote chance of exposing another to HIV in such a manner, she was sentenced to the full extent of the law, in large part based on her HIV status.[320]

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, should not be used as a substitute for legal advice.

316 *Caine*, 652 So. 2d at 616.
317 708 So. 2d 1272 (La. Ct. App. 1998).
318 *Richmond,* 734 So. 2d 33 at 38. .
319 *Richmond,* 708 So. 2d at 1276.
320 *Id.* at 1273.

Maine Statute(s) that Allow for Criminal Prosecution based on HIV Status:

No specific statute on record.

No explicit statutes regarding HIV exposure

There are no statutes explicitly criminalizing HIV transmission or exposure in Maine. However, some states have prosecuted HIV-positive people for exposing others to the virus under general criminal laws, such as those governing reckless endangerment and aggravated assault. At the time of this publication, we are not aware of a criminal prosecution of an individual on the basis of his/her HIV-positive status in Maine.

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, should not be used as a substitute for legal advice.

Maryland Statute(s) that Allow for Criminal Prosecution based on HIV Status:

MD. CODE ANN., HEALTH-GEN. § 18-601.1

Misdemeanor: knowing transfer of HIV

(a) An individual who has the human immunodeficiency virus may not knowingly transfer or attempt to transfer the human immunodeficiency virus to another individual.

(b) A person who violates the provisions of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $2,500 or imprisonment not exceeding 3 years or both.

HIV-positive persons may face misdemeanor penalties for engaging in various activities.

In Maryland, it is a misdemeanor punishable by a sentence of up to three years in prison and/or a $2,500 fine for an HIV-positive person to knowingly transfer or attempt to transfer HIV to another.[321] This law targets HIV-positive persons who are (1) aware of their HIV status and (2) knowingly engage in activities posing risks of HIV infection. Any number of HIV exposures, including consensual sexual intercourse, blood and tissue donation, breastfeeding, and/or needle-sharing, may be subject to prosecution.

On its face, neither disclosure nor the use of condoms or other protection would be an affirmative defense to prosecution. The statute potentially targets a wide range of activities without defined limitations to what conduct may or may not face potential prosecution.

Few cases in Maryland clarify the scope of this HIV exposure statute. One prosecution suggests that individuals with HIV may face prosecution regardless of whether they expose others to an actual risk of HIV transmission. In May 2008, a 44-year-old, HIV-positive man was charged with knowingly attempting to transfer HIV after he bit a police officer during an arrest. [322] He later received eighteen years in prison after pleading guilty to drug and assault charges. The officer did not test positive for HIV but such evidence is not relevant to prosecution. The CDC has concluded that there exists only a "remote" possibility that HIV could be transmitted through a bite, and such transmission would have to involve various aggravating factors including "severe trauma, extensive tissue damage, and the presence of blood."[323] Maryland's statute and its application ignore these scientific findings, leading to prosecutions for behavior that has at best a remote possibility of transmitting HIV.

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[321] MD. CODE. ANN., HEALTH-GEN. § 18-601.1 (West 2010).
[322] Amber Parcher, *HIV-positive Suspect Who Bit Officer Gets 18 Years*, GAZETTE.NET, June 4, 2008, http://www.gazette.net/stories/060408/burtnew215303_32365.shtml.
[323] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted through a human bite?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).

In March 2010, a 29-year-old, HIV-positive man was charged with seven counts of knowingly attempting to transfer HIV after he had consensual sex with a woman he met online and did not disclose his HIV status.[324] He later pleaded guilty to reckless endangerment and received eighteen months in jail.[325] The same man was charged under Maryland's HIV exposure law in 2005 after he engaged in consensual but unprotected and undisclosed, intercourse with a different woman. [326] He also pleaded guilty to reckless endangerment in that case.

HIV exposure cases have been prosecuted under general criminal laws, including attempted murder and reckless endangerment.

Prosecutions for HIV exposure in Maryland have typically arisen under general criminal laws as opposed to the 'knowing transfer of HIV' statute. General criminal law charges occur regardless of whether HIV-positive persons exposed others to significant risks of HIV infection. In Maryland, reckless endangerment, which has been used in multiple prosecutions, is defined as recklessly engaging in "conduct that creates a substantial risk of death or serious physical injury to another."[327]

In 1999, a 20-year old, HIV-positive man was convicted of second-degree assault and reckless endangerment for biting a security guard in the arm during a struggle.[328] He was sentenced to five years in jail, with all but eighteen months suspended. The guard tested negative for HIV but the transmission of HIV is not required for a prosecution for reckless endangerment.[329]

In July 2010, a 44-year old, HIV-positive defendant was sentenced to five years in prison for second-degree assault after he was convicted of spitting on a police officer.[330] Because the defendant had no teeth and often spat unintentionally, it is not clear whether the man intended to spit on the police officer. The CDC has long maintained that spitting alone has never been shown to transmit HIV and, on the basis of the facts of the case, the defendant failed to engage in conduct creating a substantial risk of death or serious injury that would warrant his conviction and five-year sentence.[331]

At least two cases in Maryland have ruled that an attempted murder charge cannot be used in cases of HIV exposure unless there is a specific intent to murder through the transmission of HIV. In 1996, a 47-year old, HIV-positive man was convicted of assault with intent to murder and sentenced to ninety years in prison after he sexually assaulted his 9-year-old step-grandson.[332] The man's sentence was later reduced to sixty years after the Maryland Court of Special Appeals ruled that his awareness of his HIV-positive status was not proof of intent to murder.[333] The boy twice tested

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[324] Patricia Murrett, *Man Sentenced for Exposing Woman He Met Online to HIV*, GAZETTE.NET, Mar. 10, 2010, http://www.gazette.net/stories/03102010/damanew224501_32560.php.
[325] *Id.*
[326] *Id.*
[327] MD. CODE ANN., CRIM. LAW § 3-204 (West 2010).
[328] Nancy A. Youssef, *HIV-positive Man Bit Security Guard in Fight, Police Say*, BALTIMORE SUN, June 20, 1999, at 5B.
[329] *Id.*
[330] Don Aines, *Man With HIV Who Spit on Police Officer Sentenced to Five Years*, HERALD-MAIL (Hagerstown, MD), July 26, 2010, http://www.herald-mail.com/?cmd=displaystory&story_id=249796&format=html&autoreload=true.
[331] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV by being spit on by an HI- infected person?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).
[332] Amy L. Miller, *Man Who Raped Step-grandson Given 90 Years*, BALTIMORE SUN, Feb. 2, 1996, at 2B.
[333] *HIV-Positive Man Convicted of Child Abuse Given Reduced Sentence,* DAILY REC. (Baltimore), July 31, 1997, at 7.

negative for HIV, but this information is not relevant in a prosecution unless it would go to show the intent of the defendant.[334]

The Court of Appeals of Maryland came to a similar conclusion in *Smallwood v. State*.[335] In *Smallwood*, an HIV-positive man was convicted of assault with intent to murder, reckless endangerment, and attempted murder after pleading guilty to attempted first-degree rape and robbery with a deadly weapon, when he raped and robbed three women at gunpoint. In addition to other sentences, the man received thirty years in prison for assault with intent to murder base on his raping the women while knowing of his HIV status. On appeal, the defendant argued that sexually assaulting the women with knowledge of his HIV-positive status was not sufficient to find an intent to kill. The prosecution countered that engaging in unprotected sexual intercourse while HIV-positive is equivalent to firing a loaded firearm at an individual, an act from which a jury could infer the intent to kill.

The court determined that the State had only provided evidence that the defendent intended to rob and rape the victims – not that he intended to kill them. The court reasoned that death by AIDS from a single exposure to HIV was not sufficiently probable to show that the defendant intended to kill his victims. The court also distinguished the defendant's case from cases in other states where intent to kill was clearly evident by evidence such as: (1) statements suggesting that a person wished to spread HIV or (2) actions solely explainable as an attempt to spread HIV, such as splashing blood.

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[334] *Id.*
[335] 680 A.2d 512 (Md. 1996).

Massachusetts Statute(s) that Allow for Criminal Prosecution based on HIV Status:

No specific statute on record.

Though there is no explicit statutes regarding HIV exposure prosecution under general criminal laws have occurred.[336]

There are no statutes explicitly criminalizing HIV transmission or exposure in Massachusetts. However, HIV-positive individuals have been prosecuted under general criminal laws in Massachusetts.

In *Commonwealth v. Smith*,[337] an HIV-positive man was indicted on charges for assault with intent to commit murder after he allegedly bit a corrections officer on the arm and screamed: "I'm HIV-positive. I hope I kill you," and "You're all gonna die, I have AIDS." Another officer testified before the grand jury that a doctor told him that HIV transmission from a human bite is possible if an attacker's gums are bloody. Despite the fact that the chances of HIV transmission from a human bite are at best remote,[338] a grand jury indicted the defendant in *Smith* and the defendant later pleaded guilty.[339] Conviction for assault with intent to commit murder can result in imprisonment of up to ten years.[340]

Smith demonstrates that HIV-positive status can be the basis for a serious criminal charge in Massachusetts, regardless of whether the complainant was exposed to any risk of HIV infection. In a 1996 case, a 38-year old man in Massachusetts was charged with assault with a "deadly weapon" after he allegedly told two police officers he had AIDS and spat at them. The police officers said that "by him spitting at us, he was attempting to infect us."[341] The CDC has long maintained that spitting alone has never been shown to transmit HIV.[342]

Murder charges may also be possible in cases where an HIV-positive person intentionally infect others with HIV and those infected later die of AIDS. In *Commonwealth v. Casanova,*[343] the court, upholding a murder conviction where the defendant shot a man who became paralyzed and died of breathing problems six years later, supported its ruling analogizing the facts to an HIV infection

[336] Mass. Gen. Laws Ann. 265 § 22b(f) (2008) mandates a fifteen-year-to-life sentence for a defendant who has forced sexual intercourse with a child under 16-years-old, the defendant "knew or should have known" that she/he was a carrier for an STI or STD, and that the minor could have contracted the STD or STI. There is no case on record that this statute has been applied to HIV-positive persons.
[337] 790 N.E.2d 708, 712 (Mass. App. Ct. 2003).
[338] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted through a human bite?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).
[339] *Smith*, 790 N.E.2d at 709.
[340] MASS. GEN. LAWS ANN. ch. 265 § 15 (West 2010).
[341] Associated Press, *AIDS Spitting Case Hits Courts*, AEGIS.COM, Dec. 12, 1996, http://www.aegis.org/news/ap/1996/AP961217.html.
[342] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted by being spit on by an HIV infected person?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).
[343] 708 N.E.2d 86, 87 (Mass. 1999).

situation where murder charges could result, even if a victim dies long into the future.[344] The defendant argued that the "year and a day" rule, no longer in effect in Massachusetts (dictating that murder charges may only result if victims die within a year and a day of an alleged attack), should be replaced by another time limit in order to protect rights to due process and a speedy trial. The Supreme Judicial Court of Massachusetts disagreed, stating that medical science had advanced enough to make arbitrary time limits unnecessary in cases where the link between an assault and a victim's death can be proven.[345]

Of course, in situations of HIV exposure there are often problems establishing if the defendant indeed infected another person. The first person to test positive can often be deemed the culprit even though she/he may have been infected by someone else, including the complainant. Even if it was the accused party who was infected first, it could have been a third party who infected the complainant. Prosecutors have been using "phylogenetic testing," which focuses on establishing a genetic connection between the HIV viruses of the two parties. But such evidence only indicates similarities in the viruses and does not prove who infected whom or the source of the virus. Such technology is also not well understood by law enforcement, attorneys, judges, or people living with HIV and fails to provide sufficient evidence for prosecution.[346]

HIV-positive status may also lead to increased prison sentences in sexual assault cases. In *Commonwealth v. Boone,*[347] an HIV-positive positive man was convicted of rape of a child and sentenced to five years in prison when he anally raped his 14-year-old cousin. The boy later revealed the events to a doctor after discovering that he was HIV-positive. On appeal, the defendant argued that at sentencing the judge improperly considered the fact that the defendant knew his HIV-positive status when he raped the boy. The Appeals Court of Massachusetts rejected this argument, agreeing with the sentencing judge that although it could not be proven that the defendant transmitted HIV to his cousin, the fact that he committed a sexual assault with knowledge of his HIV-positive status was a valid consideration during sentencing.

[344] *Id.* ("Although it will undoubtedly be difficult in many cases for the prosecution to prove causation where death is remote in time from the allegedly precipitating injury, in cases where this link can be proved, such as where a slow-acting poison is used or where a person purposely infects another with a virus such as HIV, prosecution should not be barred by some arbitrary time limit.")
[345] *Id.* at 90.
[346] RALF JURGENS ET AL., 10 REASONS TO OPPOSE THE CRIMINALIZATION OF HIV EXPOSURE OR TRANSMISSION 18 (Open Society Institute 2008).
[347] No. 02-P-536, 2003 WL 22087552, at *1 (Mass. App. Ct. Sept. 9, 2003).

Michigan Statute(s) that Allow for Criminal Prosecution based on HIV Status:

MICH. COMP. LAWS ANN. § 333.5210

333.5210 Sexual penetration as felony

(1) A person who knows that he or she has or has been diagnosed as having acquired immunodeficiency syndrome or acquired immunodeficiency syndrome related complex, or who knows that he or she is HIV infected, and who engages in sexual penetration with another person without having first informed the other person that he or she has acquired immunodeficiency syndrome or acquired immunodeficiency syndrome related complex or is HIV infected, is guilty of a felony.
(2) As used in this section, "sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.

MICH. COMP. LAWS ANN. § 333.11101

Violation: donation or sale of blood or blood products

An individual shall not donate or sell his/her blood or blood products to a blood bank or storage facility or to an agency or organization that collects blood or blood products for a blood bank or storage facility knowing that he/she has tested positive for the presence of HIV or an antibody to HIV. A blood bank or other health facility to which blood or blood products is donated in violation of this section immediately shall notify the local health department of the violation.

Engaging in sexual intercourse without disclosing HIV status can lead to felony charges.

In Michigan, it is a felony punishable by up to four years in prison[348] if a person aware that she/he is HIV-positive and engages in "sexual penetration" with a person uninformed of her/his HIV status.[349] Neither the intent to transmit HIV nor actual transmission is required.

[348] MICH. COMP. LAWS ANN. § 777.13k (West 2006) (categorizing sexual intercourse with an uninformed partner as a Cclass F, person felony). For information on minimum sentences, consult sentencing instructions at § 777.21. *See also* § 777.22 (outlining offense variables apply to different offense categories); MICH. COMP. LAWS ANN. §§ 777.31-49a (2006) (providing point system for each offense variable); § 777.67 (providing minimum sentences for Clclass F felonies). *But see* H.B. 6328, 95th Leg., 2010 Reg. Sess. (Mich. 2010) (proposing to require definite terms of imprisonment and repeal portions of Michigan's sentencing guidelines); *see also* MICH. SENTENCING GUIDELINES MANUAL (2010), *available at* http://courts.michigan.gov/mji/resources/sentencing-guidelines/sg.htm..

Michigan defines "sexual penetration" as penile-vaginal sex, oral sex, anal sex, and *any* other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body.[350] The emission of semen is not required.[351] The use of condoms or other protection during sexual penetration is not a defense.

The only defense to prosecution is if HIV-positive persons disclose their HIV status to sexual partners before engaging in sexual penetration. However, the disclosure of HIV status during private, sexual activities may be difficult to prove without witnesses or documentation, and evidence often rests of the testimonies of the parties where it is one person's word against the other. In *People v. Flynn*, a former lover of an HIV-positive man testified that she engaged in unprotected sexual intercourse with him and he failed to inform her of his HIV-positive status.[352] The man testified that he informed the complainant of his HIV status before they engaged in sexual intercourse and that he wore a condom. He further argued that the woman's testimony was inadmissible evidence against his character. The court ruled that the woman's testimony was admissible as it had the clear purpose of showing that the man had a general scheme to conceal his HIV status. In these situations, there are inherent problems when the only evidence available is the testimonies of the parties.

Despite its potential to criminalize safe sexual practices, Michigan's uninformed partner law has survived legal challenges that it is unconstitutionally overbroad.[353] In *People v. Jensen*,[354] a mentally-impaired, HIV-positive woman received three concurrent prison terms of two years and eight months to four years after she engaged in unprotected sex with a man on three occasions. On appeal, she argued that the statute failed to differentiate between consensual and nonconsensual intercourse, and would seem to require that rape victims inform their attackers of their HIV status.

The Court of Appeals of Michigan rejected this argument, finding that the defendant did not have standing to challenge the statute on such grounds because her case did not involve forced sexual intercourse. The court found that the defendant's actions of engaging in unprotected, consensual sex without disclosing her HIV status was clearly prohibited by law and rejected the defendant's argument that Michigan's uninformed partner law is unconstitutional due its lack of a clear intent requirement.

Looking to the reasoning of the Michigan legislature, the court held that the statute required only a general intent to engage in sexual penetration while failing to disclose HIV status. An HIV-positive person who fails to disclose her/his status could be considered grossly negligent because non-disclosure could only achieve the "further dissemination of a lethal, incurable disease in order to gratify the sexual or other physical pleasures of the already infected individual."[355]

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[349] MICH. COMP. LAWS ANN. § 333.5210; *See also* Doe v. Johnson, 817 F.Supp. 1382 (W.D. Mich. 1993) (finding that a woman's claims for negligent or fraudulent transmission of HIV could be maintained if defendant knew (1) that he was HIV-positive, (2) that he was suffering from HIV-related symptoms, or (3) that a prior sex partner was HIV-positive).
[350] MICH. COMP. LAWS ANN. § 333.5210(2) (2001).
[351] *Id.*
[352] People v. Flynn, No. 199753, 1998 WL 1989782, at *1 (Mich. Ct. App. Sept. 25, 1998).
[353] *See, e.g.,* People v. Jensen, 586 N.W.2d 748 (Mich. Ct. App 1998); Flynn, No. 199753, 1998 WL 1989782.
[354] 564 N.W.2d 192, 194-95 (Mich. Ct. App. 1997), *vacated in part, appeal denied in part by* 575 N.W.2d 552 (Mich. 1998).
[355] *Id.* at 754.

The Michigan Court of Appeals rejected another constitutional challenge to the state's HIV disclosure laws in *People v. Flynn*.[356] In that case, an HIV-positive man was convicted of failing to tell his sexual partners, with whom he engaged in unprotected sex, that he was HIV-positive. On appeal, he argued that Michigan's uninformed partner law was unconstitutionally overbroad, because the law's definition of "sexual penetration" included activities that could not spread the virus. The court found that the defendant had no basis for challenging the scope of the law because the defendant had engaged in unprotected sexual intercourse, which was "clearly encompassed" by the statute's language. The defendant was sentenced to two concurrent terms of thirty-two to forty-eight months in prison.

Several other HIV-positive individuals in Michigan have been prosecuted for engaging in sexual intercourse without disclosing their status to partners:

- In November 2010, a man was charged with two felony counts of sexual penetration of an uninformed partner for allegedly having sex with two women without disclosing his HIV status.[357]
- In *People v. Selemogo*,[358] an HIV-positive man received 108 to 240 months in prison for criminal sexual contact and nine months in prison for sexual penetration with an uninformed partner after he sexually assaulted a woman in her sleep.
- In *People v. Clayton*,[359] an HIV-positive man received fifty-eight months to fifteen years in prison after he allegedly engaged in unprotected anal and oral sex with a man without informing the man of his HIV status.
- An HIV-positive man received four to six years in prison in 1999 after pleading guilty to failing to disclose his HIV status to his then-girlfriend.[360]
- In September 2008, an HIV-positive man was charged with four counts of engaging in sexual penetration with an uninformed partner when he allegedly had sex with multiple women without disclosing his HIV status.[361]
- In December 2008, a 36-year-old woman pleaded guilty for failing to inform several sexual partners that she was HIV-positive. She was sentenced to the sixty-eight days

[356] *Flynn*, No. 199753, 1998 WL 1989782.
[357] Lisa LaPlante, *HIV-positive Man Charged With Having Sex, Not Telling Partners of Status*, WSBT.COM, Nov. 15, 2010, http://www.wsbt.com/news/fox17-hivpositive-man-charged-with-h-111510,0,7741407.story.
[358] No. 273410, 2008 WL 902287, at *1 (Mich. Ct. App. Apr. 3, 2008) (unpublished).
[359] No. 230328, 2002 WL 31058331, at *1 (Mich. Ct. App. Sept. 13, 2002) (unpublished), *sentencing modified after new sentencing hearing* in No. 245260, 2004 WL 895857 (Mich. Ct. App. Apr. 27, 2004) (unpublished).
[360] *Michigan Man Sentenced for Not Disclosing HIV Status*, 14 AIDS POL'Y & L. 15, Aug. 20, 1999.
[361] *Underage girls Allege Illegal Sex; HIV-positive Man Charged with Violating AIDS Disclosure Law*, GRAND RAPIDS PRESS (Michigan), Sept. 13, 2008, at A4; *see also Montcalm Man Faces Charge of Not Disclosing HIV Infection to Sex Partners*, MLIVE.COM, Sept. 5, 2008, http://www.mlive.com/news/grandrapids/index.ssf/2008/09/montcalm_county_man_faces_char.html.

in prison for time already served and five years probation.[362] The woman was arrested again after engaging in sex work and allegedly violating her probation.[363]

- In November 2009, a 21-year-old man received a nine-month prison sentence, three years probation, and a $1,250 fine after he engaged in sexual intercourse with a woman without informing her that he was HIV-positive.[364]
- In July 2009, an HIV-positive woman employed at a sex club was arrested by police informants for failing to disclose her HIV status.[365] She was sentenced to sixteen months to twenty years for failing to disclose her HIV status and for drug offenses.[366]
- In February 2009, a 25-year-old man was sentenced to two months in prison after he failed to disclose his HIV-status to several sexual partners.[367]
- In March 2010, a 54-year-old, HIV-positive woman was arrested and charged under Michigan's uninformed partner law after she allegedly engaged in sexual intercourse without disclosing her HIV status to her partner.[368]

HIV-positive blood has been considered a "harmful biological substance" under Michigan bioterrorism laws.

HIV-positive blood is a considered a "harmful biological substances" under the Michigan's bioterrorism laws[369] and exposing others to HIV-positive blood may increase prison sentences for assault or may be prosecuted as a crime of its own.

Enhanced sentences for blood exposure are possible regardless of whether HIV infection was possible under the circumstances. In *People v. Odom,* an HIV-positive inmate was convicted on three counts of assault when he allegedly punched and spat on correctional officers during an altercation.[370] Because he was bleeding from the mouth during the assault,[371] and because his saliva

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362 Rex Hall Jr., *Kalamazoo Woman with HIV is the Second Person to Face Charges Within a Month*, KALAMAZOO GAZETTE (Michigan), Oct. 8, 2008; *See also* Sarah Crone, *Woman Spared More Jail Time in HIV Case*, MLIVE.COM, Dec. 10, 2008, http://www.mlive.com/news/kalamazoo/index.ssf/2008/12/woman_spared_more_jail_time_in.html.
363 Lynn Turner, *Man with HIV Who Had Sex with Unwitting Partners Gets Jail*, KALAMAZOO GAZETTE (Michigan), Feb. 3, 2009, *available at* http://www.mlive.com/news/kzgazette/index.ssf?/base/news-32/123367623451600.xml&coll=7.
364 Kelly Dame, *Man Charged in AIDS Case Sentenced*, MIDLAND DAILY NEWS, Nov. 18, 2009, http://www.ourmidland.com/police_and_courts/article_e2dc9201-86cc-51ae-beab-b61226b1f642.html.
365 *US: Michigan Strip Club Employee Pleads No Contest to HIV Non-Disclosure (Updated)*, CRIMINALHIVTRANSMISSIONBLOGSPOT.COM, July 14, 2009, http://criminalhivtransmission.blogspot.com/2009/07/us-michigan-strip-club-employee-pleads.html.
366 Norma Lerner, *Escape Reality Dance "Star" Gets Up to 20 Years*, NILES STAR (Michigan), Sept. 21, 2009, http://www.nilesstar.com/2009/09/21/escape-reality-dancer-star-gets-up-to-20-years/.
367 Lynn Turner, *Man with HIV Who Had Sex with Unwitting Partners Gets Jail*, KALAMAZOO GAZETTE (Michigan), Feb. 3, 2009, *available at* http://www.mlive.com/news/kzgazette/index.ssf?/base/news-32/123367623451600.xml&coll=7.
368 Mark Ranzenberger, *Rosebush Woman Faces Prison on HIV Charge,* MORNING SUN (Mount Pleasant, MI), Mar. 10, 2010, http://www.themorningsun.com/articles/2010/03/10/news/doc4b98204b317bb718709599.txt.
369 *See generally* People v. Odom, 740 N.W.2d 557 (Mich. Ct. App. 2007).
370 740 N.W.2d at 560.

containing blood was deemed a "harmful biological substance" under state bioterrorism laws,[372] the spitting incident led to an increased sentence of five to fifteen years.[373]

The defendant's appeal was the first opportunity for the Michigan Court of Appeals to determine whether the blood of an individual with HIV could be considered a "harmful biological substance" under state sentencing guidelines. Relying on a statement from the CDC website that HIV can be transmitted via blood, the Court of Appeals concluded that HIV-positive blood is a "harmful biological substance," as it can "spread or cause disease in humans, animals, or plants."[374] The man's elevated sentencing was therefore upheld.[375]

Odom failed to address how state sentencing laws could apply to HIV-positive individuals who act in self-defense in an altercation, or who have no knowledge or intention of exposing another to HIV. The ruling leaves open the possibility that HIV-positive persons will be prosecuted for unintentional blood exposures that occur when they are attacked by others or are victims of prison guard misconduct. The defendant in *Odom* denied that he initiated the altercation or that he spit at the officers. Although the defendant did have a bloody mouth after his altercation with prison guards, the court did not discuss how he received his injuries.

In 2010, another HIV-positive man was charged under Michigan's bioterrorism law for allegedly biting his neighbor during an altercation. In *People v. Allen*,[376] the defendant was charged under bioterrorism laws due to the "possession" of a harmful biological substance (i.e., HIV) with the intent to frighten, terrorize, intimidate, threaten, harass, injure, or kill another.[377] There was no evidence that the man was bleeding from the mouth at the time of the bite, that he intended to transmit HIV, or that he exposed his neighbor to anything but saliva.[378]

This initial charge disregarded the fact that the CDC has concluded that there exists only a "remote" possibility that HIV could be transmitted through a bite and such transmission would have to involve various aggravating factors including "severe trauma, extensive tissue damage, and the presence of blood."[379] The CDC has also concluded that spitting alone has never been shown to transmit HIV.[380]

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[371] *Id.* at 561.
[372] *Id.; see also* MICH. COMP. LAWS ANN. § 750.200h(g) (2004) (defining "harmful biological substance" as a bacteria, virus, or other microorganism or toxic substance derived from or produced by an organism that can be used to cause death, injury, or disease in humans, animals, or plants.)
[373] *Odom*, 740 N.W.2d at 560; *see also* MICH. COMP. LAWS ANN. § 777.31(1)(b) (2006) (imposing twenty additional sentencing points for exposures to harmful biological substances).
[374] *Id.*
[375] *Id.* at 562.
[376] No. 2009-4960 (Macomb County Ct. Mich. Cir. Ct. June 2, 2010), *available at* http://www.hivlawandpolicy.org/resources/view/517.
[377] *Id.* at *2; *see also* MICH. COMP. LAWS ANN. § 750.200i(1)(a) (2004).
[378] *Allen*, No. 2009-4960 at *3.
[379] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted through a human bite?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).
[380] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted by being spit on by an HIV infected person?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).

The Macomb County Circuit Court dismissed the bioterrorism charge as unfounded. Relying on a statement from the CDC, the court acknowledged that saliva, tears, or sweat has never been shown to result in HIV transmission. However, the court also cited *Odom* and confirmed that HIV-infected blood is a "harmful biological substance" under state bioterrorism laws. Thus, *Allen* did nothing to remove the risk that an HIV-positive individual can be arrested and charged as a "bioterrorist" under Michigan state law, but did help illuminate the fallacies of prosecuting HIV-positive persons for spitting and biting.

HIV-positive status can be considered a factor in sentencing.

Under Michigan state law, a sentencing court may go beyond sentencing guidelines and impose a minimum sentence above what is recommended if there is a substantial and compelling reason to do so.[381] In the past, this provision of state sentencing guidelines has lead to increased sentences where sexual assault victims are exposed to or infected with STIs, such as HPV.[382] In *People v. Holder*, the Michigan Court of Appeals affirmed the eighty to 120 month sentence of the HIV-positive defendant's conviction for sexual penetration of an uninformed partner.[383] The court held that because the defendant did not tell his partner about his HIV status, he infected her and risked infection to his partner's as-of-then unborn child. The court found that these facts were sufficient to uphold a sentencing of twice the standard range because of the risk he presented to the complainant's child and the other potential people he could have exposed to HIV.

Donating blood or product products while HIV-positive is a criminal offense.

The Michigan Public Health Code prohibits individuals who are aware that they have tested positive for HIV from donating or selling blood or blood products (plasma, platelets, etc.).[384] Neither the intent to transmit HIV nor actual transmission is required. Disclosure of HIV status before blood sales or donations is not a defense on the face of the statute. If an individual violates this law, her/his local health department will be notified immediately, and she/he she may be declared a health threat to others.[385] The health department may send the individual an official warning, requiring that she/he participate in mandatory education programs or take legal action if the HIV-positive person continues to expose others to HIV.[386]

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[381] MICH. COMP. LAWS ANN. § 769.34(3) (2006), *limited on constitutional grounds by* People v. Conley, 715 N.W.2d 377 (Mich. Ct. App. 2006).

[382] *See, e.g.,* People v. Grissom, No. 251427, 2004 WL 2625034, at *2 (Mich. Ct. App. Nov. 18, 2004) (unpublished) ("Further, although points were scored for bodily injury requiring treatment, the guidelines do not take into account the extent of injury to this victim of the transmission of disease. In this case, the victim contracted Human Papillomavirus Virus (HPV), a disease that potentially may cause cervical cancer in the future."); People v. Castro-Isaquirre, No. 242134, 2004 WL 737489, at *2 (Mich. Ct. App. Apr. 6, 2004) (unpublished) ("Here, the trial court based its departure on the fact that defendant, who has a sexually transmitted disease, exposed the victim, her mother, and her sister to the disease.")

[383] 2003 WL 22138282 (Mich. Ct. App. 2003)(per curiam).

[384] MICH. COMP. LAWS ANN. § 333.11101 (2001).

[385] MICH. COMP. LAWS ANN. § 333.11101; *See also* MICH. COMP. LAWS ANN. § 333.5201(1)(b) (defining a "health threat to others" as "an individual who is a carrier has demonstrated an inability or unwillingness to conduct himself or herself in such a manner as to not place others at risk of exposure to a serious communicable disease or infection.").

[386] MICH. COMP. LAWS ANN. § 333.5203 (outlining the procedure for issuing a health department warning notice); s*ee also* MICH. COMP. LAWS ANN. § 333.5205 (outlining court proceedings that may result from refusing to comply with health department warnings).

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Minnesota Statute(s) that Allow for Criminal Prosecution based on HIV Status:

MINN. ST. § 609.2241
Knowing transfer of communicable disease

Subdivision 1. **Definitions.** As used in this section, the following terms have the meanings given:
(a) "Communicable disease" means a disease or condition that causes serious illness, serious disability, or death; the infectious agent of which may pass or be carried from the body of one person to the body of another through direct transmission.
(b) "Direct transmission" means predominately sexual or blood-borne transmission.
(c) "A person who knowingly harbors an infectious agent" refers to a person who receives from a physician or other health professional:
(1) advice that the person harbors an infectious agent for a communicable disease;
(2) educational information about behavior which might transmit the infectious agent; and
(3) instruction of practical means of preventing such transmission.
(d) "Transfer" means to engage in behavior that has been demonstrated epidemiologically to be a mode of direct transmission of an infectious agent which causes the communicable disease.
(e) "Sexual penetration" means any of the acts listed in section 609.341, subdivision 12, when the acts described are committed without the use of a latex or other effective barrier.

Subd. 2. **Crime.** It is a crime, which may be prosecuted under section 609.17, 609.185, 609.19, 609.221, 609.222, 609.223, 609.2231, or 609.224, for a person who knowingly harbors an infectious agent to transfer, if the crime involved:
(1) sexual penetration with another person without having first informed the other person that the person has a communicable disease;
(2) transfer of blood, sperm, organs, or tissue, except as deemed necessary for medical research or if disclosed on donor screening forms; or
(3) sharing of nonsterile syringes or needles for the purpose of injecting drugs.

Subd. 3. **Affirmative defense.** It is an affirmative defense to prosecution, if it is proven by a preponderance of the evidence, that:
(1) the person who knowingly harbors an infectious agent for a communicable disease took practical means to prevent transmission as advised by a physician or other health professional; or
(2) the person who knowingly harbors an infectious agent for a communicable disease is a health care provider who was following professionally accepted infection control procedures.

Nothing in this section shall be construed to be a defense to a criminal prosecution that does not allege a violation of subdivision 2.
Subd. 4.**Health Department data.** Data protected by section 13.3805, subdivision 1, and information collected as part of a Health Department investigation under sections 144.4171 to 144.4186 may not be accessed or subpoenaed by law enforcement authorities or prosecutors without the consent of the subject of the data.

HIV status must be disclosed to sexual partners and condoms or other protection must be used during sexual activities.

In Minnesota, HIV-positive persons must disclose their HIV status to sexual partners. It is a criminal offense for any individual who knowingly "harbors" the infectious agent for a communicable disease (i.e., HIV) to engage in sexual penetration with another person without first informing that person that she/he carries that infectious agent.[387] This offense may be charged as assault (of the first,[388] second,[389] third,[390] fourth,[391] and fifth[392] degrees), attempted assault,[393] murder (first[394] or second degree[395]), or attempted murder.[396] Potential prison sentences depend on the offense charged. However, if an HIV-positive person violates this "sexual penetration" law on multiple occasions, consecutive sentencing is possible.[397]

The statute provides that communicable diseases (i.e., HIV) may not be transmitted by engaging is behavior that has been "demonstrated to be a mode of direct transmission."[398] A "communicable disease" is defined as a disease or condition that causes serious illness, serious disability or death, or the infectious agent of which (i.e., HIV) may pass or be carried from the body of one person to the body of another through direct transmission.[399] "Direct transmission" means predominately sexual or blood-borne transmission.[400] Transferring a communicable disease is defined as engaging in behavior that has been "demonstrated epidemiologically to be a mode of direct transmission" of the

[387] MINN. STAT. § 609.2241(2)(1) (2009); *See also* MINN. STAT. § 609.2241(1)(d) (2009) (defining "transfer" as engaging in "behavior that has been demonstrated epidemiologically to be a mode of direct transmission of an infectious agent which causes the communicable disease"); MINN. STAT. § 609.2241(1)(a) (2009) (defining "communicable disease" as "a disease or condition that causes serious illness, serious disability, or death; the infectious agent of which may pass or be carried from the body of one person to the body of another through direct transmission "); MINN. STAT. § 609.2241(1)(b) (2009) (defining "direct transmission" as predominately sexual or blood-borne transmission).
[388] MINN. STAT. § 609.221 (2009).
[389] § 609.222.
[390] § 609.223.
[391] § 609.2231.
[392] § 609.224.
[393] § 609.17.
[394] § 609.185.
[395] § 609.19.
[396] § 609.17.
[397] *See* Appendix to Minnesota Sentencing Guidelines at MINN. STAT. ch. 244 App. VI.
[398] MINN. STAT. § 609.2241(1)(b)(2009).
[399] § 609.2241(1)(a).
[400] § 609.2241(1)(b).

disease.[401] The statute is limited to only prosecuting sexual activities that are known to HIV, including sexual and anal intercourses.[402]

Neither the intent to transmit HIV nor actual transmission is required for prosecution.[403]

Under the terms of this statute, any individual who is (1) advised that she/he is HIV-positive by a physical or health official, (2) receives educational materials about how HIV is transmitted, and is (3) instructed how to prevent HIV transmission, "knowingly harbors an infectious agent."[404]

It is a defense to prosecution under this statute if condoms, dental dams, or other latex barriers are used during sexual intercourse.[405] It is also a defense if HIV status is disclosed to sexual partners.[406] However, it should be noted that the disclosure of HIV status or the use of condoms or other protection during private, sexual activities may be difficult to prove without witnesses or document. The statute also holds that an HIV-positive individual prosecuted under this "knowing transfer" law may have a defense to prosecution if she/he can prove that she/he took practical means to prevent HIV transmission as advised by a doctor or health care professional.[407]

In March 2010, a 28-year old, HIV-positive man was charged with third-degree assault after he engaged in sexual intercourse with two men without disclosing his HIV status.[408] At least one of the men tested positive for HIV but such information is not relevant to the prosecution.[409] In October 2009, an HIV-positive man pleaded guilty to intentionally inflicting or attempting to inflict bodily harm on another (misdemeanor assault in the fifth-degree) and was sentenced to ninety days in jail after he had unprotected sex with a woman without disclosing his HIV status.[410]

HIV-positive persons are prohibited from donating their blood, organs, semen, or body tissues.

Minnesota's "knowing transfer laws" also prohibit HIV-positive persons from transferring their blood, semen, organs, or body tissues to others.[411] This activity may be charged as assault (of the

[401] § 609.2241(1)(d).
[402] It is important to note that Minnesota's definition of "sexual penetration" includes multiple types of activity that do not transmit HIV. (See MINN. STAT. § 609.2241(1)(e) (2009) (citing MINN. STAT. § 609.341(12) (2009), *amended by* 2010 Minn. Sess. Law Serv. Ch. 270 (S.F. 2717) (West)). This definition is cited by many other statutes (i.e., sexual assault and aggravated sexual assault statutes) and is overly broad for the purposes of the HIV exposure statute. It was probably a legislative oversight to include the entire definition of "sexual penetration" in the HIV exposure statute, as the HIV exposure statute specifically notes that only behavior known to transmit HIV may be prosecuted and the use of latex barrier protection is an affirmative defense. This suggests that it was not the intent of the legislature to prosecute sexual activities that are not known to transmit HIV and the entire definition of "sexual penetration" is not applicable to Minnesota's HIV exposure law.
[403] *See* MINN. STAT. § 609.2241(1)(d).
[404] *See* MINN. STAT. § 609.2241(1)(c) (2009).
[405] MINN. STAT. § 609.2241(1)(e).
[406] MINN. STAT. § 609.2241(2)(1)
[407] MINN. STAT. § 609.2241(3) (2009).
[408] Vince Tuss, *Assault Charged in HIV Case*, STAR TRIB. (Minneapolis), Mar. 25, 2010, at 1B.
[409] *Id.*
[410] *Man Sentenced for HIV Exposure*, PIONEER PRESS (St. Paul), Oct. 28, 2009; *See also Minnesota Man Receives 90 days in Jail for Exposing Woman to HIV*, POZ, Oct. 28, 2009, http://www.poz.com/articles/duluth_hiv_exposure_1_17491.shtml.
[411] MINN. STAT. § 609.2241(2)(2).

first,[412] second[413], third,[414] fourth,[415] and fifth[416] degrees), attempted assault,[417] murder (first[418] or second degree[419]), or attempted murder.[420] Although sentences will depend on which offense is charged, consecutive sentencing is possible if an individual violates this law on multiple occasions.[421] The intent to transmit HIV nor actual transmission is required for prosecution.

Prosecution will not result if (1) the transfer of blood, semen, organ, or tissue was deemed necessary for medical research, or (2) HIV-positive individuals disclose their HIV status on donation forms before transferring these bodily fluids and tissues.[422]

Sharing needles or syringes may lead to criminal penalties.

It is unlawful for a person who is HIV-positive to transfer the virus to another by sharing non-sterile needles/syringes for the purpose of injecting drugs.[423] Under Minnesota sentencing laws, consecutive sentencing is possible if an HIV-positive person shares a needle/syringe on multiple occasions.[424]

Although disclosing HIV status to sexual partners may prevent prosecution in Minnesota, on the face of the statute it is not a defense if HIV status is disclosed before sharing needles with another. Prosecution for HIV exposure may result even if an HIV-positive person shares a needle with another individual fully aware of her/his HIV status and understands the risk to HIV exposure.

Neither the intent to transmit HIV nor actual transmission is required for prosecution.

HIV-positive status results in enhanced prison sentences for sex offenses.

Under Minnesota sentencing guidelines, a defendant may receive a sentence higher than what is recommended if aggravating circumstances make her/his conduct more serious than the conduct normally involved in the commission of the offense.[425] A defendant's exposure of sexual assault victims to sexually transmitted infections (STI) or HIV has been used as a justification for elevated

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412 § 609.221(2009).
413 § 609.222.
414 § 609.223.
415 § 609.2231.
416 § 609.224.
417 § 609.17.
418 § 609.185.
419 § 609.19.
420 § 609.17.
421 *See* MINN. SENTENCING GUIDELINES app. (2009), *available at* MINN. STAT. ch. 244 App. VI.
422 MINN. STAT. § 609.2241(2)(2)(2009).
423 § 609.2241)(2)(3).
424 *See* Appendix to Minnesota Sentencing Guidelines at MINN. STAT. ch. 244 App. VI.
425 *See* MINNESOTA SENTENCING GUIDELINES COMMISSION, MINNESOTA SENTENCING GUIDELINES AND COMMENTARY (2010), http://www.msgc.state.mn.us/guidelines/guide10.pdf, at 28-35.

prison sentences.[426] In *State v. Vance*, a man who sexually assaulted a 16-year-old girl received a prison sentence twenty-nine months higher than usual due to (1) his victim's young age, and (2) the fact that he infected her with both venereal warts and pubic lice.[427] In *Perkins v. State*, a man with AIDS received the statutory maximum of thirty years in prison for a sexual assault (three times higher than the sentence recommended by guidelines).[428]

HIV-positive criminal defendants may receive enhanced sentences regardless of whether they transmit HIV to sexual assault victims. At the time of trial in *Perkins*, it was not made public whether or not the woman involved was infected with HIV, but such facts were not necessary for the enhanced sentencing.[429] The trial judge who sentenced the HIV-positive man remarked that he could not "fathom on the face of this earth if there was a more devastating offense to a victim than being sexually assaulted by a person with AIDS. The victim of this offense will not know for several months whether or not she contracted the HIV virus."[430]

Note on civil commitment: Under the "civil commitment" laws of Minnesota, an individual found to be "sexually dangerous," a "sexual psychopathic," or "mentally ill and dangerous" can be indefinitely confined by the state to protect the public safety.[431] New York State has attempted to use a similar law to impose further punishments for HIV exposure (*See* New York). In 2008, a civil commitment proceeding was initiated against an HIV-positive man in *In re Renz*.[432] Renz appealed his commitment for being "mentally ill and dangerous," arguing that though he is mentally ill he is not dangerous and his commitment should only be for his mental illness.[433] To be confined as "mentally ill and dangerous," in addition to having a mental illness, the person must present a "clear danger to the safety of others" because she/he has "engaged in an over act causing or attempting to cause serious physical harm to another" and there is a "substantial likelihood that the person will engage in acts capable of inflicting serious harm on another."[434] Renz contended that there was no clear and convincing evidence that he engaged in any act causing or attempting to cause physical harm to another.

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[426] *See* Kilcoyne v. State, 344 N.W.2d 394, 397 (Minn. 1984) (viewing defendant's transmission of trichomaras vaginalis to sexual assault victim as an aggravating factor justifying elevated sentencing); State v. Taylor, No. C3-88-74, 1988 WL 75555 (Minn. Ct. App. June 26, 1998) (unpublished) (affirming an elevated sentence based partly on defendant's transmission of gardnerella to victim); State v. Banks, No. C1-94-1491, 1995 WL 118922, at *2 (Minn. Ct. App. Mar. 21, 1995) (unpublished) (viewing the transmission of venereal disease to a sexual assault victim as an aggravating factor during sentencing).

[427] State v. Vance, 392 N.W.2d 679, 684 (Minn. Ct. App. 1986).

[428] Perkins v. State, 559 N.W.2d 678, 683-85 (Minn. 1997); s*ee also* State v. Sebasky, 547 N.W.2d 93, 100-101 (affirming a triple departure from the recommended sentence for criminal sexual conduct where defendant knew he was HIV-positive while sexually abusing two boys), *denial of post-conviction relief affirmed by* Sebasky v. State, No. A05-507, 2006 WL 463619 at *1 (Minn. Ct. App. Feb. 28, 2006).

[429] *Perkins*, 559 N.W.2d at 682, 684.

[430] *Id.* at 684.

[431] MINN. STAT. § 253B.185 (2007), *amended by* 2010 Minn. Sess. Law Serv. Ch. 300 (S.F. 2713), Ch. 357 (H.F. 2612), Ch. 385 (H.F. 3787).

[432] In re Renz, No. A08-898, 2008 WL 4706962 (Minn. Ct. App. 2008)

[433] There are stark differences between being committed for being "mentally ill" versus commitment for "mentally ill and dangerous." This includes the place and duration of commitment as well as the procedures for being discharged. *See* MINN. STAT.§§ 253B.09, 253B.18 (2006).

[434] MINN. STAT. § 253B.02(17) (2006).

The court held that because Renz knew his HIV status and engaged in unprotected, undisclosed sex with his partners, such activity was a danger to others. The court reasoned that because of Renz's history of unprotected sex, as evidenced by his contracting gonorrhea and syphilis, he presented a danger despite the fact that there was no evidence of a specific person or instance of such sexual conduct. The court also noted that though earlier case law held that any commitment of an HIV-positive person who intended to have sexual intercourse with others without advising them of his HIV status had to be addressed by the Health Threat Procedures Act rather than civil commitment,[435] one's HIV status would not preclude civil commitment if other requirements of the law were met. Here, the court found that due to Renz's sexual history, he met the requirements for commitment as mentally ill and dangerous.

Note on coercion: Under Minnesota victims' rights laws, any individual coerced into sex work by another person may pursue a civil action against that person.[436] Evidence of "coercion" may include "exploiting HIV status, particularly where the defendant's previous coercion led to the HIV exposure."[437]

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[435] In re Stilinovich, 479 N.W.2d 731, 735-36 (Minn. Ct. App. 1992) (finding the use of Minnesota's "psychopathic personality" statute inappropriate for civil commitment where HIV-positive defendant failed to show concern for the risk of HIV transmission through sexual intercourse). *In re Stilinovich* pre-dates Minnesota's HIV exposure and "sexually dangerous person" laws.
[436] MINN. STAT. § 611A.81 (2009).
[437] § 611A.80(2)(22).

Mississippi Statute(s) that Allow for Criminal Prosecution based on HIV Status:

MISS. CODE ANN. § 97-27-14(1)

Exposure to HIV, hepatitis B, or hepatitis C

It shall be a felony for any person to knowingly expose another person to HIV, hepatitis B, or hepatitis C. Prior knowledge and willing consent to the exposure is a defense to a charge brought under this statute.

MISS. CODE ANN. § 97-27-14(2)

Endangerment by bodily substance with knowledge of HIV status

A person commits the crime of endangerment by bodily substance if the person attempts to cause or knowingly causes a corrections employee, a visitor to a correctional facility, or another prisoner or offender to come into contact with blood, seminal fluid, urine, feces, or saliva. A violation of this subsection is a misdemeanor unless the person violating this section knows that he is infected with HIV, hepatitis B, or hepatitis C, in which case it is a felony.

MISS. CODE ANN. § 97-27-14(3)

Penalties for felony HIV exposure or endangerment by bodily fluids

Any person convicted of a felony violation of this section shall be imprisoned for not less than three years nor more than ten years and/or a fine of not more than $10,000.

MISS. CODE ANN. § 41-23-2

Violating the lawful order of a health officer

Any person who shall knowingly and willfully violate the lawful order of the county, district or state health officer where that person is afflicted with a life-threatening communicable disease or the causative agent thereof shall be guilty of a felony and, upon conviction, shall be punished by a fine not exceeding $5,000 or by imprisonment in the penitentiary for not more than five years, or both.

A broad range of HIV exposures may result in imprisonment.

In Mississippi, it is a felony punishable by up to ten years in prison and/or a $10,000 fine if an HIV-

positive person knowingly exposes another to HIV.[438]

Neither the intent to transmit HIV nor actual transmission is required for conviction.

It is a defense to prosecution if the complainant (1) is aware of the other's HIV status and (2) willingly consents to HIV exposure. Disclosure is a complete defense in Mississippi; however, proving disclosure of HIV status during private, sexual encounters is difficult without witnesses or documentation. Whether or not disclosure actually occurred is often open to interpretation and always depends on the words of one person against another.

The only prosecution on record for HIV exposure in Mississippi occurred in October 2008, when a 28-year-old wife pleaded guilty to knowingly exposing her husband to HIV after she failed to tell him that she was HIV-positive.[439] The woman allegedly knew she was HIV-positive since 1997, but never told her husband, whom she married in 2003. Under the terms of her plea agreement, she received a ten-year prison sentence, with nine years suspended and one year to be served under house arrest. Neither the woman's ex-husband nor her five-year-old son tested positive for HIV though such facts play no role in a prosecution.

Exposing prisoners, prison guards, or prison visitors to bodily fluids is prohibited.

Mississippi's HIV statute specifically targets HIV-positive inmates who throw or otherwise expose others to their bodily fluids during confrontations. It is a misdemeanor punishable by up to one year in jail and/or a $1,000 fine[440] if a person attempts to cause or knowingly causes a corrections employee, visitor to a correctional facility, or fellow prisoner or offender to come into contact with her/his blood, seminal fluid, urine, feces, or saliva.[441] A violation of this law becomes a felony, punishable by up to ten years in prison and/or a $10,000 fine,[442] if an individual convicted knew that she/he was HIV-positive.[443]

This "bodily substance" statute may cover a large class of persons beyond prisoners and prison guards. Under the terms of this statute, "offenders" include anyone in the custody of the department of corrections and "prisoners" include anyone confined in a city or county jail.[444] "Corrections employees" include any employee of an agency or department responsible for operating a jail, prison, or correctional facility, or anyone working in these facilities.[445] Exposing visitors to these facilities is also criminalized.[446]

Neither the intent to transmit HIV nor actual transmission is required.

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[438] MISS. CODE ANN. § 97-27-14(1) (West 2010).
[439] Nicklaus Lovelady, *Wife Gets House Arrest in HIV Case*, CLARION LEDGER, Oct. 7, 2008 at 1B.
[440] MISS. CODE ANN. § 97-27-14(4) (West 2010).
[441] § 97-27-14(2).
[442] § 97-27-14(3) .
[443] § 97-27-14(2)(c).
[444] § 97-27-14(2)(b)(ii)-(iii).
[445] § 97-27-14(2)(b)(i).
[446] § 97-27-14(2)(a).

This statute imposes additional fines and prison sentences for offenders who are HIV-positive, regardless of whether they expose others to a risk of HIV infection. An HIV-positive offender will serve up to ten times more prison time than an HIV-negative offender, even if the "bodily substance" in question is urine, feces, or saliva, which pose only theoretical risks of HIV infection.

Furthermore, because attempting to expose others to bodily substances is punishable, it is not a defense that these substances did not come into contact with another or that HIV transmission was impossible under the circumstances.

Violating a quarantine order of the health department is a felony.

Imprisonment may result from violating directions from the state health department. HIV-positive persons may be mandated by the health department to disclose their HIV status to sexual partners and avoid intravenous drug use.

Under the public health and quarantine laws of Mississippi, the state department of health is authorized to "investigate and control the causes of epidemic, infectious and other disease affecting the public health."[447] Part of this authority includes the power to "establish, maintain and enforce isolation and quarantine," and "to exercise such physical control over property and individuals as the department may find necessary for the protection of the public health."[448] It is a felony, punishable by up to five years in prison and/or a $5,000 fine, for an individual afflicted with a "life-threatening communicable disease" to willfully violate an order of the state health department issued under this authority.[449]

Individuals living with HIV in Mississippi should be aware that this public health law has been used to prosecute at least one HIV-positive person for failing to disclose his HIV status to sexual partners.[450] In *Carter v. State*, the health department of Mississippi issued a quarantine order against an HIV-positive man and labeled him a potential danger to the public health after he tested positive for HIV.[451] The man was ordered to (1) disclose his HIV status to sexual partners and (2) abstain from engaging in activities involving the mixture of his blood with the blood of another (i.e., intravenous drug use). The man was sentenced to five years in prison after being convicted of failing to tell a sexual partner that he was infected with HIV.

The only impetus for the defendant's quarantine order was a positive test for HIV. Under the terms of the order, using protection during sexual intercourse was not a defense.

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[447] MISS. CODE ANN. § 41-23-5 (West 2010).
[448] § 41-23-5.
[449] MISS. CODE ANN. § 41-23-2 (West 2010).
[450] Carter v. State, 803 So. 2d 1191 (Miss. Ct. App. 1999).
[451] *Id.* at 1192-93.

Missouri Statute(s) that Allow for Criminal Prosecution based on HIV Status:

MO. REV. STAT. § 191.677

1. It shall be unlawful for any individual knowingly infected with HIV to:

(1) Be or attempt to be a blood, blood products, organ, sperm or tissue donor except as deemed necessary for medical research;
(2) Act in a reckless manner by exposing another person to HIV without the knowledge and consent of that person to be exposed to HIV, in one of the following manners:

(a) Through contact with blood, semen or vaginal secretions in the course of oral, anal or vaginal sexual intercourse; or
(b) By the sharing of needles; or
(c) By biting another person or purposely acting in any other manner which causes the HIV-infected person's semen, vaginal secretions, or blood to come into contact with the mucous membranes or nonintact skin of another person.

Evidence that a person has acted recklessly in creating a risk of infecting another individual with HIV shall include, but is not limited to, the following:

a. The HIV-infected person knew of such infection before engaging in sexual activity with another person, sharing needles with another person, biting another person, or purposely causing his or her semen, vaginal secretions, or blood to come into contact with the mucous membranes or nonintact skin of another person, and such other person is unaware of the HIV-infected person's condition or does not consent to contact with blood, semen or vaginal fluid in the course of such activities;
b. The HIV-infected person has subsequently been infected with and tested positive to primary and secondary syphilis, or gonorrhea, or chlamydia; or HIV status.
c. Another person provides evidence of sexual contact with the HIV-infected person after a diagnosis of an HIV status.

2. Violation of the provisions of subdivision (1) or (2) of subsection 1 of this section is a class B felony unless the victim contracts HIV from the contact in which case it is a class A felony.

3. The department of health and senior services or local law enforcement agency, victim or others may file a complaint with the prosecuting attorney or circuit attorney of a court of competent jurisdiction alleging that a person has violated a provision of subsection 1 of this section. The department of health and senior services shall assist the prosecutor or circuit attorney in preparing such case, and upon request, turn over to peace officers, police officers, the prosecuting attorney or circuit attorney, or the attorney general records concerning that person's HIV-infected status, testing information, counseling received, and the identity and available contact information for individuals with whom that person had sexual intercourse or deviate sexual intercourse and those individuals' test results. [*continued on next page*]

MO. REV. STAT. § 191.677 *[continued from previous page]*

4. The use of condoms is not a defense to a violation of paragraph (a) of subdivision (2) of subsection 1 of this section

MO. REV. STAT. § 565.085

Exposure to HIV in prison facilities

An offender or prisoner commits the crime of endangering a corrections employee, a visitor to a correctional facility, or another offender or prisoner if she/he attempts to cause or knowingly causes such person to come into contact with blood, seminal fluid, urine, feces, or saliva.

It is a Class C felony if the offender has HIV, hepatitis B, or hepatitis C, or exposes another to the HIV, hepatitis B, or hepatitis C.

MO. REV. STAT. § 567.020

Prostitution while HIV-positive

Performing an act of prostitution, which is normally a Class B misdemeanor, becomes a Class B felony if the prostitute knew prior to performing the act of prostitution that she/he was infected with HIV. The use of a condom is not a defense.

MO. REV. STAT. § 558.011

Prison sentences

For a Class A felony, a term of imprisonment not less than ten years and not more than thirty years.

For a Class B felony, a term of imprisonment not less than five years and not more than fifteen years.

For a Class C felony, a term of imprisonment of no more than seven years.

It is a felony to fail to disclose one's HIV status to sexual partners, and condom use is not a defense.

Missouri's HIV-exposure statute makes it a felony punishable by up to fifteen years in prison, or as many as thirty years if HIV is transmitted, for an HIV-positive person who knows her/his status to recklessly expose someone, without disclosing their status, through contact with blood, semen, or

vaginal secretions during oral, anal, or vaginal sex.[452] Other proscribed contact includes contact of certain fluids with mucus membranes, and the sharing of needles.

The only affirmative defense under this statute is if one has disclosed her/his HIV status to sexual partners prior to engaging in sexual conduct.[453] Disclosure of HIV status can be difficult to prove in court, as the only evidence available is often the word of one party against that of another.

In *State v. Yonts*, a trial court found that even if one does eventually disclose her/his HIV status to her/his sexual partner, and the parties continue to be sexually intimate after such disclosure, the HIV-positive person can still face prosecution unless the disclosure was done prior to the first sexual encounter.[454] In *Yonts*, the HIV-positive defendant was sentenced to one-year imprisonment for exposing his girlfriend, the complainant, to HIV.[455] Though the defendant testified that he disclosed his HIV status prior to any sexual conduct, the complainant testified it wasn't until a year into their relationship that the defendant told her he was HIV-positive.[456] After the later disclosure, according from the complainant, she continued to have unprotected sex with him because she thought that the medication the defendant was taking would prevent HIV transmission – which may have been the case if he had a low viral load. The complainant did not test positive for HIV, but such facts were irrelevant to the prosecution.

It is difficult to comprehend how a jury could possibly find the defendant's actions "reckless" when the complainant still engaged in unprotected sex with full knowledge of the man's status. This case serves as a stark example of the difficulty in defending oneself against accusations of HIV exposure and proving disclosure to sexual partners under criminal HIV transmission statutes.

It is specifically noted in the statute that disclosure is the only affirmative defense to prosecution.[457] Any unprotected sexual contact can be considered reckless.[458] In *State v. Wilson*, the HIV-positive defendant was convicted of, amongst other charges, reckless exposure to HIV.[459] On appeal, the defendant argued he could not be convicted under the statute because he ejaculated outside the body and therefore did not recklessly expose the complainant's mucus membrane to HIV. The Missouri Supreme Court concluded that, "while withdrawal would have been relevant to the jury's determination of recklessness, the statute does not contemplate that withdrawal is in itself a complete defense."[460] The jury could have concluded that ejaculating outside of the body negated the element of recklessness, and thus could have acquitted, but the jury concluded that unprotected contact was reckless because it posed some possibility of transmission.

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[452] MO. REV. STAT. §§ 558.011, 565.085 (West 2010).
[453] State v. Wilson, 256 S.W.3d 58, 64 (Mo. 2008) ("The statute is unambiguous that one who knows he is HIV-positive is reckless [and subject to prosecution] if he has sexual intercourse with another without making the other person aware of his HIV status." Neither condom use nor ejaculating outside of the body is a defense).
[454] 84 S.W.3d 516 (Mo. Ct. App. 2002) (appealed on the sole issue of whether trial court erred is allow evidence of how defendant may have contracted HIV over the defense's objection. The court found that the evidence was not prejudicial enough to deprive the defendant of a fair trial).
[455] *Id.*
[456] *Id.* at 518.
[457] MO. REV. STAT. § 565.08(4) (West 2010).
[458] *Wilson*, 256 S.W.3d at 64.
[459] *Wilson,* 256 S.W. 3d 58.
[460] *Id.* (the court also noted that the State had provided evidence that HIV can be transmitted by sexual fluids even if the actor withdraws prior to ejaculation).

The Missouri statute has been unsuccessfully challenged for being unconstitutionally vague.[461] In *State v. Mahan*, the Missouri Supreme Court consolidated the appeals of two men who were convicted under the Missouri statute for failing to inform their sexual partners that they were HIV-positive.[462] One of the men, Sykes, was sentenced to ten years imprisonment for having sex with two women, including his live-in girlfriend, and failing to disclose his HIV status. The other man, Mahan, was sentenced to five years imprisonment for failing to tell his sexual partner that he was HIV-positive.

The appellants argued that the statute was overly broad and criminalized behavior such as an HIV-positive mother giving birth to her child. The court held that the appellants lacked standing on this matter because their behavior directly fell within the language of the statute and, as such, they could not challenge hypothetical scenarios that were not reflective of their behavior. The appeal by one of the defendants, Mahan, also argued that the statute was overly vague, as the phrase "grave and unjustifiable risk" did not provide enough notice as to what acts can be prohibited under the statute. Specifically, Mahan reasoned that because the risk of transmitting HIV was not quantitatively known to scientists, a person would have no way of knowing when one's conduct would rise to a "grave and unjustifiable risk."[463] The court found because Mahan was counseled that HIV could be transmitted through unprotected sex, including anal sex, and he continued to have anal sex without disclosing his HIV status, the statute was not vague as applied to him, and he had full notice that his actions could result in the transmission of HIV. The court upheld both of the convictions.

One notable aspect of Missouri's law is that one can be prosecuted under this statute if, in addition to HIV, the defendant tests positive for syphilis, gonorrhoea, or chlamydia.[464] Positive test results for STIs are used by Missouri officials to show that HIV-positive persons are engaging in unprotected sex. This statute allows prosecutors to more easily prosecute HIV-positive persons charged with failing to tell a sexual partner about their HIV status because, as opposed to relying on facts and witness testimony, prosecutors can rely on the defendant's medical records to prove that she/he was "recklessly" having unprotected sex and placing others at risk. This segment of the statute all but eliminates the need for complainant testimony and other evidence to prove whether or not the defendant engaged in undisclosed, "reckless" sex. This unjustly prosecutes persons based on their medical history as opposed to the facts of a case.[465]

The Missouri statute also provides that if a complainant tests positive for HIV and one of her/his former sexual partners is found to be HIV-positive, this would be enough to bring a charge of HIV

[461] State v. Mahan, 971 S.W.2d 307 (Mo. 1998).
[462] *Id.*
[463] *Id* at 312. (It is important to note that there have been many scientific studies since *State v. Mahan* concluding that HIV has a very low rate of transmission even in the most aggravating of circumstances).
[464] MO. REV. STAT. § 191.677(2)(c)(b) (West 2010).
[465] The Centers for Disease Control and Prevention (CDC) have found that persons who are infected with syphilis are two-five times more likely to acquire HIV when exposed to the virus because the sores, ulcers, or breaks in skin or mucus membrane caused by syphilis break down the barriers against infection. *CDC Fact Sheet: Syphilis*, Ctr. for Disease Control and Prevention, Dec. 2007, http://www.cdc.gov/std/syphilis/syphilis-fact-sheet.pdf. The CDC has also found that people with gonorrhea can more easily contract and transmit HIV. *CDC Fact Sheet: Gonorrhea*, Ctr. for Disease Control and Prevention, Dec 2007, http://www.cdc.gov/std/chlamydia/ChlamydiaFactSheet-lowres-2010.pdf . And people with chlamydia can more easily contract HIV. *CDC Fact Sheet: Chlamydia*, Ctr. for Disease Control and Prevention, May 2010, http://www.cdc.gov/std/chlamydia/ChlamydiaFactSheet-lowres-2010.pdf.

exposure.[466] Under the statute the prosecution would have to prove a sexual relationship existed between the complainant and HIV-positive defendant and that the HIV-positive defendant knew of her/his HIV-positive status at the time of the sexual activity.[467] This statute enables prosecutions of persons where, without direct evidence as to the actual source of the infection, the defendant can face up to thirty years imprisonment for transmitting HIV.[468]

Other cases and prosecutions for exposing[469] persons to HIV in Missouri include:

- In 2004, a man pleaded guilty and was sentenced to fifteen years imprisonment for five counts of exposing his sexual partners to HIV without disclosing his HIV status.[470]
- An HIV-positive man was convicted of two counts of exposing his sexual partners to HIV and was sentenced to ten years imprisonment in addition to being convicted as a sex offender.[471]
- A man was convicted of exposing his ex-girlfriend to HIV because he failed to tell her that he was HIV-positive.[472]
- In 2000, an HIV-positive man was convicted of exposing his former girlfriend to HIV and was sentenced to five years imprisonment. His sentence was later suspended and he was placed on five years probation and fined $5,000.[473]
- A 43-year-old man was arrested for failing to disclose his HIV status to his sexual partners.[474]
- In 2009, a 40-year-old HIV-positive man was charged with exposing his sexual partner to HIV after allegedly failing to disclose his HIV status.[475]

Sexually violent predator statutes have been applied to persons in Missouri based solely on their HIV-positive status.

In the Missouri Court of Appeals case, *In re Coffel*, an HIV-positive woman's status was the determining factor in her three-year civil confinement as a sexually violent predator.[476] Missouri defines a sexually violent predator as "any person who suffers from a mental abnormality which makes the person more likely than not to engage in predatory acts of sexual violence if not confined

[466] MO. REV. STAT. § 191.677(1)(2)(c)(c) (West 2010).
[467] *Id.*
[468] MO. REV. STAT. §§ 191.677, 558.011 (West 2010).
[469] In one case an HIV-negative man was convicted of attempted murder and sentenced to life imprisonment for injecting his son with HIV-positive blood. This case did not involve a prosecution based on the defendant's HIV status, because the defendant was HIV-negative, but rather involved the prosecution of a man who tried to murder his son using HIV-positive blood. State v. Stewart, 18 S.W.3d 75 (Mo. Ct. App. 2000).
[470] Spicer v. State, 300 S.W.3d 249 (Mo. Ct. App. 2009).
[471] State v. Newlon, 216 S.W.3d 180 (Mo. Ct. App. 2007).
[472] State v. White, 247 S.W.3d 557 (Mo. Ct. App. 2007).
[473] State v. Moss, 83 S.W.3d 604 (Mo. Ct. App. 2002).
[474] *Man Charged for Knowingly Spreading HIV*, KSPR NEWS, Feb. 12, 2008, *available at* http://www.kspr.com/news/local/15553847.html.
[475] *Missouri Man with HIV Charged with Reckless Sexual Contact*, KANSAS CITY STAR (MO), Sept. 23, 2009.
[476] In re Coffel, 117 S.W.3d 116 (Mo. Ct. App. 2003).

in a secure facility and who [...] has pled guilty or been found guilty [...] of a sexually violent offense."[477]

Coffel pleaded guilty to two counts of sodomy based on an incident that took place when she was 18-years-old. In 1994, she, on a dare, placed the penises of an 11-year-old and 13-year-old boy briefly in her mouth. When the boys discovered she was HIV-positive they reported the incident. After pleading guilty she was sentenced to five years imprisonment and though a pre-sentencing report said she was not a sexual predator, her end-of-confinement evaluation determined that due to her lack of remorse or concern about the possibility of infecting others with HIV, she was more likely than not to re-offend and should be considered a sexually violent predator.

At trial, a multidisciplinary team as well as a psychologist determined that Coffel was not a sexual predator. In particular the psychologist noted that the end-of-confinement report was based in large part on the erroneous assumption that Coffel's saliva could have transmitted HIV during the acts of sodomy, and that she intended to transmit HIV. The trial court, despite this evidence, ordered her to be confined indefinitely.

On appeal, the Missouri Court of Appeals focused on whether the state had met its burden in proving that Coffel was more likely than not to commit another sexually violent crime, as required by the sexually violent predator statute. The court found that only two out of ten of the State's witnesses addressed whether Coffel was likely to commit the crime again, and that the expert testimonies did not base their opinions on psychological theories but rather on private, subjective, untested, unsupported analysis. Based on this evidence, the court ordered Coffel's release because the state failed to meet its burden. This case highlights the extent to which a person's HIV status can be erroneously applied in civil confinement and sexually violent predator status.

Acts known not to transmit HIV, such as spitting,[478] are punishable by felony penalties of five to fifteen years' imprisonment.

Under Missouri's exposure statute, it is a felony to bite, or by acting purposefully in any other manner, to expose someone to the semen, vaginal secretions, or blood of an HIV-positive person.[479] The CDC has concluded that there exists only a "remote" possibility that HIV could be transmitted through a bite and such transmission would have to involve various aggravating factors including "severe trauma, extensive tissue damage, and the presence of blood."[480] The CDC has also concluded that spitting alone has never been shown to transmit HIV.[481] Missouri's statute and its

[477] Mo. Rev. Stat. § 632.480(5) (West 2010).
[478] In most cases involving spitting individuals have been charged under the specific HIV-criminalization statute. However, in November 2010 a man who claimed he had HIV was charged with two counts of assault for allegedly threatening and spitting on police officers. Kathryn Wall, *Man Claiming He Has HIV Charged in Assault on Officers*, NEWS-LEADER.COM, Nov. 2, 2010, http://www.news-leader.com/article/20101102/NEWS01/11020343/Man-claiming-he-has-HIV-charged-in-assault-on-officers.
[479] Mo. Rev. Stat. §§ 191.677(1)(2)(c) (West 2010).
[480] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted through a human bite?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).
[481] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted through by being spit on by an HIV infected person?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).

application ignore these scientific findings, leading to prosecutions for behavior that has at best a remote possibility of transmitting HIV.

In 2010, an HIV-positive man was charged with exposure to HIV for spitting at a police officer.[482]

In a case from 2004, an HIV-positive man was arrested for knowingly exposing another to HIV after he bit a police officer.[483] Though the man had been intoxicated, as his blood alcohol level was twice the legal limit, and probably had no intention of transmitting HIV, the prosecutor noted that "the law doesn't distinguish between whether he intended to give the officer HIV or not. The mere fact that he bit him constitutes reckless exposure, and he can be charged and convicted for that."[484]

It is a felony to expose prison guards, prison visitors, and others prisoners to HIV through bodily fluids.

In Missouri, it is a Class D felony, punishable by up to four years in prison,[485] for a HIV-negative person in confinement to attempt to cause or knowingly cause a correctional employee,[486] visitor to a correctional facility, or fellow prisoner to come into contact with her/his blood, semen, urine, feces, or saliva.[487] A violation of this statute becomes a Class C felony, punishable by up to seven years in prison[488] if the incarcerated person is infected with HIV, hepatitis B, or hepatitis C.[489] Areas of confinement covered by this statute include prisons, jails, sex offender treatment centers, and any other correctional facilities.[490] Neither the intent to transmit HIV nor actual transmission is required for prosecution.

This "endangerment" statute imposes specific penalties for offenders who are HIV-positive, even if they expose others to fluids that cannot transmit HIV or *attempt* to expose others to the bodily fluids listed. It is not a defense if HIV transmission was impossible under the circumstances. This statute is not based on scientific evidence, but rather fear, stigma, and perpetual ignorance about HIV transmission.

Under this statute, there is also a risk of prosecution if a prisoner begins to bleed during a fight, and a complainant claims that he was intentionally exposed to the blood. The facts surrounding sporadic fights are hard to determine, and because juries often consider the testimony of HIV-positive criminal defendants less credible than an HIV-negative complainant regarding HIV exposure, this statute has the potential of imposing additional prison sentences for HIV-positive

[482] *Seymour Man Charged with Recklessly Exposing Someone to HIV*, KSPR NEWS, June 1, 2010, http://www.kspr.com/news/local/95346789.html
[483] *Man Accused of HIV Exposure*, KANSAS CITY STAR (MO), June 11, 2004, at B4.
[484] *Id.*
[485] MO. ANN. STAT. § 558.011 (West 2010).
[486] A "correctional employee" receiving protection under this statute includes any person who is an employee of any department or agency responsible for operating a jail, prison, correctional facility, or sex offender treatment center or any person assigned to work in these locations. MO. ANN. STAT. § 565.085(2)(1) (West 2010).
[487] MO. ANN. STAT. § 565.085 (West 2010).
[488] § 558.011.
[489] § 558.011(3).
[490] § 565.085.

inmates who accidentally and unintentionally expose others to their blood due to an injury sustained during a fight.

HIV-positive persons face potential criminal penalties if they donate blood, organs, semen, or tissue unless such donation is for medical research.

It is a Class B felony, carrying a sentence of five to fifteen years, for an HIV-positive person to donate any blood, blood products, organs, sperm or tissue, unless the donation is for medical research.[491]

It is a felony for an HIV-positive person to share needles and not disclose one's HIV status.

If HIV-positive persons fail to disclose their HIV status to fellow needle sharers, it is a Class B felony punishable by five to fifteen years in prison.[492] However, if the complainant tests positive for HIV then the HIV-positive defendant can be sentenced to a Class A felony with the possibility of ten to thirty years' imprisonment.[493]

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, should not be used as a substitute for legal advice.

[491] MO. REV. STAT. §§ 191.677(1)(1), 558.011.
[492] MO. REV. STAT. §§ 191.677(1)(2)(b), 558.011.
[493] MO. REV. STAT. §§ 191.677(2), 558.011.

Montana Statute(s) that Allow for Criminal Prosecution based on HIV Status:

MONT. CODE. ANN. §§ 50-18-112, 50-80-113

Violation of a Misdemeanor

A person infected with an STD may not knowingly expose another person to infection. HIV is considered an STD for the purposes of this statute (MONT. CODE ANN. § 50-80-101).

Exposing another to an STI, including HIV, is punishable via a communicable disease control statute.

It is a misdemeanor,[494] punishable by up to six months in county jail and/or a $500 fine,[495] for a person with a sexually transmitted disease to "knowingly" expose another to that disease.[496] HIV is considered an STD for the purposes of this exposure law.[497] Though this statute may target HIV, at the time of the manual's publication, there has been no recorded prosecution of HIV exposure. Also, communicable disease statutes tend to go unenforced for any STI exposure, including HIV. (*See* Introduction).

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, should not be used as a substitute for legal advice.

[494] MONT. CODE ANN. § 50-18-113 (1967).
[495] § 46-18-212 (1973).
[496] § 50-18-112 (1967).
[497] § 50-18-101 (1993).

Nebraska Statute(s) that Allow for Criminal Prosecution based on HIV Status:

NEB. REV. STAT. § 28-934 (2011)

Assault with a bodily fluid against a public safety officer; penalty; order to collect evidence

Any person who knowingly and intentionally strikes any public safety officer with any bodily fluid is guilty of assault with a bodily fluid against a public safety officer. A person who violates this provision is guilty of a misdemeanor unless he or she knew the source of the bodily fluid was infected with the human immunodeficiency virus, hepatitis B, or hepatitis C at the time the offense was committed, making the violation a Class IIIA felony punishable by a maximum term of imprisonment of nt more than 5 years, or by a fine of not more than $10,000, or by both fine and imprisonment.

Upon a showing of probable cause that such an offense has been committed, a judge shall grant a court order or search warrant authorizing the collection of medical test results or medical records and may authorize tests to determine the presence of human immunodeficiency virus, hepatitis B, or hepatitis C.

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, it should not be used as a substitute for legal advice.

Nevada Statute(s) that Allow for Criminal Prosecution based on HIV Status:

NEV. REV. STAT. § 201.205

Intentional transmission of HIV: penalty and affirmative defense

A person who, after testing positive in a test approved by the State Board of Health for exposure to the human immunodeficiency virus and, receiving actual notice of that fact, intentionally, knowingly, or willfully engages in conduct in a manner that is intended or likely to transmit the disease to another person is guilty of a category B felony and shall be punished by imprisonment in the state prison for a minimum term of not less than 2 years and a maximum term of not more than 10 years, or by a fine of not more than $10,000, or by both fine and imprisonment.

It is an affirmative defense to an offense charged if the person who was subject to exposure to the human immunodeficiency virus as a result of the prohibited conduct: knew the defendant was infected with the human immunodeficiency virus; knew the conduct could result in exposure to the human immunodeficiency virus; and consented to engage in the conduct with that knowledge.

NEV. REV. STAT. § 201.358

Engaging in prostitution or solicitation for prostitution after testing positive for exposure to human immunodeficiency virus

A person who works as a prostitute in a licensed house of prostitution after testing positive in a test approved by the State Board of Health for exposure to the human immunodeficiency virus and receiving notice of that fact is guilty of a category B felony and shall be punished by imprisonment in the state prison for a minimum term of not less than 2 years and a maximum term of not more than 10 years, or by a fine of not more than $10,000, or by both fine and imprisonment.

NEV. REV. STAT. § 441A.300

Confinement of a Person Whose Conduct May Spread Acquired Immunodeficiency Syndrome

A person who is diagnosed as having acquired immunodeficiency syndrome who fails to comply with a written order of a health authority, or who engages in behavior through which the disease may be spread to others, is, in addition to any other penalty imposed pursuant to this chapter, subject to confinement by order of a court of competent jurisdiction.

NEV. REV. STAT. § 441A.180

Contagious person to prevent exposure to others; warning by health authority; penalty

A person who has a communicable disease in an infectious state shall not conduct herself /himself in any manner likely to expose others to the disease or engage in any occupation in which it is likely that the disease will be transmitted to others. A person who violates this provision after service upon her/him of a warning from a health authority is guilty of a misdemeanor.

HIV-positive persons are prohibited from engaging in conduct known to transmit HIV.

In Nevada, it is a Class B felony, punishable by two to ten years in prison and/or a fine of up to $10,000, for a person who knows she/he is HIV-positive to intentionally engage in conduct that is intended or likely to transmit the disease to another person. Actual transmission of HIV is not required under the statute.

Though the statute is entitled "intentional transmission" of HIV, neither intent to expose another to HIV nor transmission is required. A person must only engage in conduct "likely to transmit HIV" regardless of any specific intent to expose another person to HIV. Conduct "likely to transmit" HIV is not defined under the statute.

Nevada law provides an affirmative defense to the intentional transmission of HIV if the other person who was subject to possible HIV exposure knew the defendant was HIV-positive, knew that the conduct in which they were engaging could lead to HIV exposure, and voluntarily engaged in the conduct. This most likely applies to sexual activities or needle sharing, although the statute does not explicitly define such conduct. At a minimum, disclosure must occur prior to engaging in any acts known to transmit HIV. It may be difficult to prove whether one's HIV status was disclosed in the course of private sexual activities, because whether or not disclosure actually occurred is often open to interpretation and always depends on the words of one person against another. Condom use without disclosure is not a defense to prosecution.

In June 2010, in what appears to be a case of first impression[498] under the statute, two men were charged with felony intentional transmission of HIV for engaging in sex with an HIV-negative man whom they had met on Adam4Adam, a male dating website.[499] One of the defendant's, who has an undetectable viral load, HIV status was prominently displayed on his dating profile, and he

[498] Prior to this incident, at least one case held that a person's HIV status is relevant to whether there was consent during sexual intercourse. In *Shelton v. State*, the court held that the defendant's HIV status was relevant for determining whether the complainant in the case had agreed to engage in unprotected oral sex. 2009 WL 1490929 (Nev. 2009). The defendant was convicted of first-degree kidnapping, sexual assault of a minor under 16 years of age, battery with the intent to commit sexual assault of a minor under 16 years of age, and the use of a minor in the production of pornography.

[499] Interview with defendant and his attorney, names have been omitted to protect the identities of the parties (Nov. 11, 2010).

maintains that the claimant was fully aware of his HIV status. In exchange for a guilty plea, the felony charges were reduced to gross misdemeanor charges for intentional transmission of HIV, carrying a maximum sentence of one year in county jail.

Engaging in acts of prostitution while HIV-positive can result in felony charges.

Nevada is the only state that has legalized prostitution, and it is a misdemeanor for anyone to engage in prostitution except in a licensed "house of prostitution."[500] As prostitution is regulated, sex workers must be tested monthly for HIV and STIs and are required to wear latex condoms.[501] In Nevada, it is a Class B felony, punishable by two to ten years in prison and/or a fine of up to $10,000, for an HIV-positive sex worker to engage in licensed or unlicensed sex work after knowledge of his/her HIV-positive status.

In *Glegola v. State*, the Nevada Supreme Court affirmed a sex worker's conviction and fifteen-year sentence for solicitation while being HIV-positive, even though she testified that she did not actually intend to perform any sexual acts and did not engage in any activities that could transmit HIV.[502] The defendant testified that her only intent was to steal the undercover agent's money, without engaging in any sexual activities, and she should therefore not be prosecuted under the statute. No sexual act was committed, and she was taken into custody after offering sexual services. She produced multiple witnesses to testify to such facts on her behalf. The defendant also argued that her fifteen-year sentence[503] was cruel and unusual punishment and disproportionate to the crime for which she was convicted. The court found that both the conviction and sentencing were appropriate because the "harm threatened by the act of solicitation of prostitution while HIV-positive is great."[504] The "legislature did not intend for the unsuspecting client to be fatally infected […] [and as such] her crime should be treated differently [as] it is much more serious and obviously much more deadly than an ordinary crime of mere solicitation defined as a misdemeanor."[505]

Such severe sentences may create an incentive for unlicensed prostitutes (who are not mandated by the state to do monthly HIV testing) to avoid being tested for HIV. If unlicensed prostitutes continue to work without knowledge of their HIV status they, at worst, face a misdemeanor conviction for being unlicensed carrying a sentence of no more than six months. However, if they continue to work knowing their positive HIV status, they can face felony penalties of up to ten years imprisonment.

Nevada also imposes penalties on HIV-positive persons for failing to comply with health authorities.

An HIV-positive person who ignores or fails to comply with orders from health authorities, and engages in behavior known to transmit HIV, may be subject to confinement and criminal

[500] NEV. REV. STAT. § 244.345 (West 2010).
[501] NEV. ADMIN. CODE § 441A.800-815 (2010).
[502] 871 P.2d 950 (Nev. 1994).
[503] Since the decision in *Glegola*, the penalties for violating Nev. Rev. Stat. § 201.358 have been revised, decreasing the maximum sentence to ten years from fifteen years.
[504] *Glegola v. State*, 81 P.2d at 953.
[505] *Id.*

penalties.[506] There are no records of a person being subject to prosecution or penalties under this statute.

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[506] NEV. REV. STAT. § 441A.300 (1989).

New Hampshire Statute(s) that Allow for Criminal Prosecution based on HIV Status:

No specific statute on record.

No explicit statute criminalizing HIV exposure but prosecutions have arisen under general criminal laws.

There are no statutes explicitly criminalizing HIV transmission or exposure in New Hampshire. However, there has been at least one prosecution for HIV exposure under the state's general criminal laws.

In the 2002 case *State v. CJ,* the New Hampshire Superior Court held that exposure to HIV could be prosecuted under the state's assault and reckless conduct statutes.[507] The defendant was an HIV-positive man who did not disclose his HIV status to his girlfriend before they engaged in unprotected sexual activities, and only disclosed his status after the relationship had ended and she was pregnant. On these facts, the defendant was charged with second-degree assault for recklessly causing serious psychological injuries to his former girlfriend and with four counts of reckless conduct for four other occasions that they engaged in unprotected sex.[508] The defendant moved to dismiss the charges, arguing that because New Hampshire had no law specifically criminalizing exposure the HIV, then the legislature must not have intended to criminalize acts known to transmit HIV.

The Court held that the seminal fluid and sexual organs of an HIV-positive person are objectively capable of causing serious bodily injury and/or death and as such should be considered a "deadly weapon" for the purposes of the state's assault and reckless conduct statutes when the activities involve unprotected sex. The Court found that the conduct the defendant allegedly engaged in was capable of inflicting bodily harm or death due to the nature of HIV, and how it is transmitted. The defendant's motion to dismiss was denied and the case was ordered to be sent to a jury for trial. Though there is no law specifically targeting HIV exposure, HIV-positive persons should disclose their status and/or wear condoms or other protection during sex.

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[507] State v. CJ, No. 01-S-726, 2002 WL 31059244, at *1 (N.H. Super. Ct. May 23, 2002).
[508] *Id. See also* N.H. REV. STAT. ANN § 631:2(B) (2010); N.H. REV. STAT. ANN. § 631:3 (2010).

New Jersey Statute(s) that Allow for Criminal Prosecution based on HIV Status:

N.J. STAT. ANN. § 2C: 34-5

Diseased person committing an act of sexual penetration

a. A person is guilty of a crime of the fourth degree who, knowing that he or she is infected with a venereal disease such as chancroid, gonorrhea, syphilis, herpes virus, or any of the varieties or stages of such diseases, commits an act of sexual penetration without the informed consent of the other person.

b. A person is guilty of a crime of the third degree who, knowing that he or she is infected with human immune deficiency virus (HIV) or any other related virus identified as a probable causative agent of acquired immune deficiency syndrome (AIDS), commits an act of sexual penetration without the informed consent of the other person.

N.J. STAT. ANN. §§ 2C:43-6; 2C:43-3

Sentence for imprisonment of a crime: Third Degree

A crime of the third degree shall be punishable between three and five years imprisonment and/or a maximum fine of $15,000.

An HIV-positive person must disclose her/his status to sexual partners.

In New Jersey a person who knows that she/he is HIV-positive may be criminally liable for a crime punishable by up to five years in prison and/or up to a $15,000 fine for having sex with another person without disclosing her/his HIV status.[509] Neither intent nor actual transmission of HIV is necessary for conviction.

In March 2010, a twenty-year-old, HIV-positive man was charged under New Jersey's diseased persons statute for having sexual relations with two women without disclosing his HIV status.[510] It is not known whether either woman tested positive for HIV, but such facts are irrelevant to prosecution.

HIV-positive persons have been prosecuted under general criminal laws, including attempted murder, in HIV exposure cases.

[509] N.J. STAT. ANN. § 2C: 34-5 (1997).
[510] Michael Buck, *HIV-positive Man Charged with Second Sex Crime in Hunterdon County*, LEHIGH VALLEY LIVE, Mar. 10, 2010, http://www.lehighvalleylive.com/hunterdon-county/express-times/index.ssf/2010/03/hiv-positive_man_charged_with.html.

In *State v. Smith*, the New Jersey Superior Court Appellate Division upheld the conviction and twenty-five-year sentence of an HIV-positive inmate who was found guilty of attempted murder, aggravated assault, and terrorist threats for biting a corrections officer.[511] The correctional officer did not test positive for HIV, but that was not relevant to the prosecution. The court acknowledged that there was only a theoretical possibility that HIV is transmitted through biting or saliva, but the conviction was upheld because the defendant subjectively believed he could cause the death of the corrections officer and intended to do so.[512]

The defendant offered evidence at trial and on his appeal that he knew that HIV could not be transmitted through biting because he had been counseled on the matter from various health professionals, and therefore, his threats were only made to take "advantage of the ignorance and fears of his jailors."[513] The court discounted this evidence and instead relied upon the threats the defendant made to the correctional officer as sufficient evidence that the defendant subjectively believed that HIV could be transmitted via a bite and saliva, and therefore intended to infect the correctional officer with HIV. Although such transmission would have been impossible, impossibility is not a defense under New Jersey law.[514]

In 1994, a 17-year-old woman was charged as an adult on charges of attempted murder and aggravated assault for biting a juvenile detention officer, with the possible sentence of twenty-five years imprisonment.[515] At the time of the indictment, it was not confirmed if the girl had tested positive for HIV, only that "she believ[ed]" she had HIV.

In another case, the New Jersey Superior Court Law Division found that a hypodermic needle purportedly infected with HIV is a deadly weapon.[516] A deadly weapon is defined as an object "which in the manner it is used or is intended to be used, is known to be capable of producing death or serious bodily injury."[517]

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[511] 621 A.2d 493 (N.J. Super. Ct. App. Div. 1993). This case was tried prior to New Jersey's diseased person's statute amended in 1997 to include HIV.
[512] *Id.*
[513] *Id.* at 511-14.
[514] *Id.* at 511.
[515] Joseph F. Sullivan, *Girl Who Thinks She has AIDS to Stand Trial for Biting of Guard*, N.Y. TIMES, Aug. 31, 1994, at B6. This case also occurred prior to New Jersey amending its diseased person's statute.
[516] State v. Ainis, 721 A.2d 329 (N.J. Super. Ct. Law Div. 1998).
[517] *Id.* at 331.

New Mexico Statute(s) that Allow for Criminal Prosecution based on HIV Status:

No specific statute on record.

No explicit statute

There are no statutes explicitly criminalizing HIV transmission or exposure in New Mexico. However, in some states, HIV-positive people have been prosecuted for HIV exposure under general criminal laws, such as reckless endangerment and aggravated assault.

At the time of this publication, the only criminal prosecution that the authors were aware of was that of an HIV-positive woman was charged with battery for licking the cheek and mouth of a police officer.[518] The news article did not make clear whether the battery charge was based off of the woman's HIV status.

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[518] *Woman Charged for Licking Officer,* ALBUQUERQUE JOURNAL, Aug. 17 1998, at B8.

New York Statute(s) that Allow for Criminal Prosecution based on HIV Status:

> **NY PUB. HEALTH LAW § 2307** provides that someone who knows that she/he is infected with an "infectious venereal disease" and has sexual intercourse with another is guilty of a misdemeanor. But there is no indication in New York statutes that HIV infection is considered a "venereal disease."

New York law is not defined on whether there are criminal penalties for HIV exposure.

In New York, a person who is aware that she/he is living with an infectious venereal disease may be guilty of a misdemeanor if she/he has sexual intercourse with another person. HIV is not identified as an infectious venereal disease under this statute, but there is nothing preventing its inclusion. Neither the intent to transmit not actual transmission of HIV is necessary for a conviction. The statute provides no indication of whether disclosure of one's status, consent prior to engaging in sexual activity, or using protection would be a defense under the statute.

There are no reports of prosecutions of persons with HIV under this statute.

HIV-positive persons have been prosecuted under general criminal laws.

In 1997, Nushawn Williams pleaded guilty to two counts of statutory rape and two counts of reckless endangerment and was sentenced to twelve years imprisonment.[519] The Williams case was heavily covered in the media after local public health and law enforcement officials publicized it, claiming that Williams may have transmitted HIV to numerous women in upstate New York. As Williams' sentence was nearing completion, on April 13, 2010, New York Attorney General Andrew Cuomo sought to keep Williams in indefinite civil confinement for sex offenders under the Sex Offender Management Treatment Act of 2007.[520] A civil jury trial will determine whether or not he suffers from a mental abnormality and should be confined in a psychiatric facility or released under intensive supervision.

In *People v. Hawkrigg*,[521] the county court denied the defendant's motion to dismiss the indictment of charges for third-degree sodomy, reckless endangerment, and endangering the welfare of a child because there was sufficient evidence to show that defendant engaged in the acts knowing that he had AIDS and that such conduct could transmit HIV. The court found that this evidence was sufficient to support a reckless endangerment charge because reckless endangerment only requires proof that the defendant consciously disregarded a substantial and unjustifiable risk that her/his conduct would result in the transmission of HIV.

New York courts have also found that HIV can be considered a "deadly weapon." In 2007, an HIV-positive man was found guilty of aggravated assault and sentenced to ten years in prison for biting a police officer. In that case, the judge found that the saliva of an HIV-positive person could be

[519] Danny Hakim, *Cuomo Moves to Block Release of Nushawn Williams*, N.Y. TIMES, Apr. 14, 2010, at A20.
[520] *Id.*
[521] 525 N.Y.S.2d 752 (Suffolk County Ct. 1988).

considered a "deadly weapon" for the purposes of aggravated assault, despite the fact that there is no scientific evidence to support such a claim.[522] In another case, *People v. Nelson*,[523] the court held that a hypodermic needle which the defendant claimed contained the AIDS virus, constituted a "dangerous instrument" under New York law.

At least one New York court has allowed access to medical records to determine a defendant's HIV status for criminal charges. In an attempted assault and reckless endangerment case, the court granted the state's motion to have access to the defendant's medical records to prove whether or not she was HIV-positive for the reckless endangerment charges.[524] The Rockland County Court found that there was a "compelling need"[525] to disclose the defendant's confidential HIV information, as the state needed to show whether the defendant biting the complainant created a grave risk of death or a depraved indifference to human life. Such claims could only be sustained if the defendant was HIV-positive.

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[522] Brief for Lambda Legal Defense and Education Fund, Inc. et al. as Amici Curiae in Support of Defendant-Appellant, X v. The People of New York, ___ N.Y. ___ (2010) (The identifying information has been redacted to protect the identity of the defendant. The brief can be found at http://www.hivlawandpolicy.org/resources/view/526).
[523] 627 N.Y.S.2d 412 (N.Y. App. Div. 1995).
[524] In re Gribetz, 605 N.Y.S.2d 834 (Rockland County Ct. 1994).
[525] *Id.*

North Carolina Statute(s) that Allow for Criminal Prosecution based on HIV Status:

10A N.C. ADMIN. CODE 41A.0202

Control measures – HIV

Infected persons shall:

a. refrain from sexual intercourse unless condoms are used; exercise caution when using condoms due to possible condom failure;
b. not share needles or syringes, or any other drug-related equipment, paraphernalia, or works that may be contaminated with blood through previous use;
c. not donate or sell blood, plasma, platelets, other blood products, semen, ova, tissues, organs, or breast milk;
d. have a skin test for tuberculosis;
e. notify future sexual intercourse partners of the infection;
f. if the time of initial infection is known, notify persons who have been sexual intercourse and needle partners since the date of infection; and,
g. if the date of initial infection is unknown, notify persons who have been sexual intercourse and needle partners for the previous year.

N.C. GEN. STAT. ANN. § 103A-144

Investigation and control measures

All persons shall comply with control measures, including submission to examinations and tests, prescribed by the Commission subject to the limitations of G.S. 130A-148.

N.C. GEN. STAT. ANN. § 130A-25

Violation of these control measures is a misdemeanor. Special provisions related to sentencing and release apply. But no person shall be imprisoned for longer than two years. No person shall be released prior to the completion of the term of imprisonment and it has been determined that the person is no longer be a danger to the public health.

HIV exposure is prohibited under the health code and can result in incarceration.

Although there is no specific HIV-related criminal transmission statute in North Carolina, HIV is considered a communicable disease requiring compliance with health regulations and control

measures governing the spread of such a disease.[526] A maximum of two years imprisonment may occur from violating these regulations, and individuals will not be released before the end of their sentence unless they are no longer considered a public danger by local authorities.[527]

Condoms or other protection must be used during sexual intercourse, and HIV status must be disclosed.

HIV-positive persons must notify all sexual partners that they have tested positive for HIV. If the date of infection is known, sexual or needle partners from that date forward must be notified of the individual's HIV status. Otherwise, all such partners from the year prior to testing positive for HIV must be notified.

The North Carolina regulation does not provide guidance on what activities are considered "sexual intercourse," and whether oral sex or anal sex is included in the definition. Any acts of sexual intercourse require, under the statute, the use of condoms and disclosure.

In August 2008, a 23-year-old, HIV-positive man was sentenced to thirty months of probation for having unprotected sex with numerous partners. He was later sentenced to six months of house arrest for further acts of unprotected sex.[528]

HIV-positive persons are prohibited from donating blood, organs, human tissue, semen, or breast milk.

Under North Carolina's Administrative Code, persons who are HIV-positive must not donate or sell blood, plasma, platelets, any other blood products, semen, ova, tissues, organs, or breast milk.

Sharing needles while being HIV-positive can result in criminal penalties.

North Carolina's Administrative Code prohibits individuals who are HIV-positive from sharing needles, syringes, or any other drug paraphernalia that may be contaminated with blood.

HIV-positive persons are also subject to general criminal laws in North Carolina.

In many states, including North Carolina, HIV exposure is often prosecuted under general criminal laws such as assault or reckless endangerment. In 2009, a 41-year-old, HIV-positive man was charged with assault and battery with intent to kill in North Carolina after biting his neighbor. The original simple assault and battery charge was upgraded for the sole reason that the alleged attacker was HIV-positive, despite the fact the CDC has concluded that there exists only a "remote" possibility that HIV could be transmitted through a bite and such transmission would have to involve various aggravating factors including "severe trauma, extensive tissue damage, and the

[526] N.C. GEN. STAT. § 130A-144(f) (2010).
[527] § 130A-25(b)-(c) (2010).
[528] *Gay DJ Put on House Arrest for Second HIV Violation*, WRAL.COM, Oct. 21, 2008, http://www.wral.com/news/news_briefs/story/3781930/.

presence of blood."[529] The CDC has also concluded that spitting alone has never been shown to transmit HIV.[530]

At least two courts have found that HIV is can be considered a "deadly weapon" for purposes of sexual assault cases. In 2005, a man was convicted of, among other charges, sexual assault with a deadly weapon inflicting serious injury and violation of control measures[531] for having sex with an underage boy.[532] The boy later tested positive for HIV but transmission is irrelevant for prosecution.[533] In *State v. Monk*, the North Carolina Court of Appeals determined that charges of assault with deadly weapon and attempted murder, which arose from fact that defendant was HIV-positive when he sexually assaulted the minor victim, were properly joined with charges of first-degree statutory rape and taking indecent liberties with minor.[534]

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[529] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted through a human bite?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).
[530] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission: Can HIV be transmitted by being spit on by an HIV infected person?*, (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Oct. 19, 2010).
[531] The control measure charges were dismissed due to the statute of limitations. *State v. Murphy*, 612 S.E.2d 694 (N.C. Ct. App. 2005).
[532] State v. Murphy, 612 S.E.2d 694 (N.C. Ct. App. 2005).
[533] *Id.*
[534] 511 S.E.2d 332 (N.C. Ct. App. 1999).

North Dakota Statute(s) that Allow for Criminal Prosecution based on HIV Status:

N.D. CENT. CODE § 12.1-20-17

Transfer of body fluid that may contain the human immunodeficiency virus

A person who, knowing that he or she has HIV, willfully transfers any of his or her body fluid to another person is guilty of a Class A felony. It is an affirmative defense that, if the transfer was by sexual activity, the activity took place between consenting adults after full disclosure of the risk of the activity and with the use of an appropriate prophylactic device. "Body fluid" means semen, blood, or vaginal secretion. "Transfer" means to engage in sexual activity by genital-genital contact, oral-genital contact, or anal-genital contact, or to permit the reuse of a hypodermic syringe, needle, or similar device without sterilization.

N.D. CENT. CODE §12.1-32-01

Classification of Offenses: Class A Felony

A Class A felony is punishable by a maximum of twenty years imprisonment and/or a fine of $10,000.

HIV status must be disclosed before sexual activity and condoms or other protections must be used.

In North Dakota, a person who is aware that she/he is HIV-positive may be criminally liable and face penalties of twenty years in prison and a $10,000 fine if she/he engages in sexual activity, including penile-vaginal sex, anal sex, and oral sex, with another person without disclosing her/his status. It is an affirmative defense if the HIV-positive person disclosed her/his status and used condoms or other protection during the sexual activity.

Neither the intent nor actual transmission of HIV is necessary for a conviction under this statute. At the time of this publication there were no HIV-related prosecutions for exposure in North Dakota.

HIV-positive persons may not share needles.

In North Dakota, a person who is aware that she/he is HIV-positive may be criminally liable if she/he transfers blood or bodily fluids to another person by allowing them to use a needle or syringe previously used by the HIV-positive person without first sterilizing it. Neither actual transmission nor intent to transmit HIV is necessary for a conviction.

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information may or may not be applicable to your specific situation and, as such, it should not be used as a substitute for legal advice.

Ohio Statute(s) that Allow for Criminal Prosecution based on HIV Status:

OHIO REV. CODE ANN. § 2903.11

Felonious assault

(A) No person shall knowingly do either of the following: (1) Cause serious physical harm to another or to another's unborn, or (2) Cause or attempt to cause physical harm to another or to another's unborn by means of a deadly weapon or dangerous ordnance.

(B) No person, with knowledge that the person has tested positive as a carrier of a virus that causes acquired immunodeficiency syndrome, shall knowingly do any of the following: (1) Engage in sexual conduct with another person without disclosing that knowledge to the other person prior to engaging in the sexual conduct, (2) Engage in sexual conduct with a person whom the offender knows or has reasonable cause to believe lacks the mental capacity to appreciate the significance of the knowledge that the offender has tested positive as a carrier of a virus that causes acquired immunodeficiency syndrome, or (3) Engage in sexual conduct with a person under eighteen years of age who is not the spouse of the offender. ("Sexual conduct" is defined in OHIO. REV. CODE ANN. § 2903.11(E)(4)).

OHIO REV. CODE ANN. §§ 2907.24

Solicitation after positive HIV test

No person, with knowledge that the person has tested positive for HIV, shall engage in, or solicit another person to engage in, sexual activity for hire. Violation of this statute is a felony of the third degree.

OHIO REV. CODE ANN. §2907.241

Loitering to engage in solicitation after positive HIV test

No person who is HIV-positive, with the purpose to solicit another to engage in sexual activity for hire and while in or near a public place, shall do any of the following: beckon, stop, or attempt to stop another; engage or attempt to engage another in conversation; stop or attempt to stop the operator of a vehicle or approach a stationary vehicle; or if the offender is the operator of or a passenger in a vehicle, stop, attempt to stop, beckon to, attempt to beckon to, or entice another to approach or enter the vehicle of which the offender is the operator or in which the offender is the passenger. Violation of this statute is a fifth-degree felony.

OHIO REV. CODE ANN. §§ 2907.25

Prostitution after positive HIV test

No person, with knowledge that the person has tested positive for HIV, shall engage in sexual activity for hire. Violation of this statute is a felony of the third degree.

OHIO REV. CODE ANN. §2921.38

Harassment by inmate

No person, with knowledge that the person is HIV-positive and with intent to harass, annoy, threaten, or alarm another person, shall cause or attempt to cause the other person to come into contact with blood, semen, urine, feces, or another bodily substance by throwing the bodily substance at the other person, by expelling it upon the other person, or in any other manner. Violation of this statute is a third-degree felony.

OHIO REV. CODE ANN. §2927.13

Sale or donation of blood by AIDS carrier

No person, with knowledge that she/he is HIV-positive, shall sell or donate her/his blood, plasma, or a product of her/his blood, if he or she knows or should know the blood, plasma, or product of her/his blood is being accepted for the purpose of transfusion to another individual. Violation of this statute is a felony in the fourth degree.

OHIO REV. CODE ANN. §2929.14

Prison terms

For a felony of the second degree: two, three, four, five, six, seven, or eight years.

For a felony of the third degree: one, two, three, four, or five years.

For a felony of the fourth degree: six, seven, eight, nine, ten, eleven, twelve, thirteen, fourteen, fifteen, sixteen, seventeen, or eighteen months.

For a felony of the fifth degree: six, seven, eight, nine, ten, eleven, or twelve months.

OHIO REV. CODE ANN. §2929.14

Possible financial sanctions

For a felony of the second degree, not more than $15,000;

For a felony of the third degree, not more than $10,000;

For a felony of the fourth degree, not more than $5,000;

For a felony of the fifth degree, not more than $2,500.

HIV-positive persons can be prosecuted for failing to disclose their HIV status to sexual partners.

Ohio's felonious assault statute specifically criminalizes failing to disclose one's HIV-positive status to sexual partners. Under this statute it is also a felony punishable by up to eight years imprisonment for engaging in sexual conduct with a person who cannot appreciate one's HIV status or engaging in such conduct with someone under the age of eighteen.

"Sexual conduct" includes penile-vaginal sex, anal sex, oral sex, and, without consent, the insertion, however slight, of any part of the body or any instrument that carries the bodily fluids of an HIV-positive person into another's vagina or anus.[535]

The only affirmative defense to prosecution is the disclosure of one's HIV status to sexual partners prior to engaging in any of the above-mentioned conduct. The disclosure must be made prior to the first initial act of such conduct and using condoms or other forms of protection is not a defense.

Neither the intent to transmit HIV nor HIV transmission is required for prosecution.

Ohio's felonious assault statute has survived constitutional challenges. In *State v. Gonzalez*, the defendant was convicted of two counts of felonious assault for failing to tell his sexual partner that he was HIV-positive. He was sentenced to sixteen years imprisonment and was required to register as a sex offender.[536] The complainant later tested positive for HIV. At trial, there were numerous discrepancies in the parties' testimony, including whether or not Gonzalez told the complainant that he was HIV-positive prior to their sexual relationship. Gonzalez testified that the complainant asked him before they began their sexual relationship whether the rumors about him being HIV-positive were true and he confirmed that he had tested positive for HIV and insisted that they use condoms every time they had sex. The complainant, however, testified that when she confronted Gonzalez he denied his HIV status and claimed that they only used a condom once. In addition to the testimony of the defendant and complainant, the defendant had an ex-girlfriend testify that he had disclosed his HIV status to her and always insisted on using condoms.

On appeal, Gonzalez argued, among other issues, that the statute was unconstitutionally vague. He asserted that the statute did not provide enough information on what constitutes "disclosure," whether such disclosure had to be made prior to each sexual contact with the same person, or whether disclosure needed to be in writing. To survive a void for vagueness challenge the statute must be written so that a person of common intelligence can determine what conduct is prohibited and the statute must provide sufficient standards to prevent arbitrary and discriminatory enforcement. The court rejected the defendant's void for vagueness argument because the ordinary meaning of "disclose" is used in every day speech and therefore cannot be vague. The court reasoned that if an HIV-positive person disclosed her/his status once to a sexual partner then this would negate guilt for any subsequent contact the person had with that partner. Verbal disclosure was also held to be sufficient as the court reasoned it was disingenuous to suggest that written, signed, and notarized disclosure would be necessary to avoid prosecution.

[535] OHIO REV. CODE ANN. § 2903.11(E)(4)(1996).
[536] 796 N.E.2d 12 (Ohio Ct. App. 2003).

The court also held that thought there was a violation of the state's HIV confidentiality statutes when the prosecution failed to obtain court authorization for Gonzalez's HIV status, this was deemed "harmless error" because of the other evidence of the defendant's HIV status.

As *State v. Gonzalez* demonstrates, it is very difficult to prove disclosure in court. In many of these cases, there is no proof that an HIV-positive person disclosed her/his status and the only evidence available is the testimony of the defendant, complainant, or other witnesses.

Below are other examples of prosecutions under Ohio's felonious assault[537] HIV exposure statute:

- In October 2010, a man was charged with felonious assault for allegedly failing to tell his wife that he was HIV-positive.[538] After the man was admitted to the hospital with pneumonia his doctor allegedly threatened to tell the man's wife about his HIV status if the man didn't disclose.

- In 2010, a 51-year-old HIV-positive man pleaded guilty to felonious assault and was sentenced to five years imprisonment for failing to tell his wife that he was HIV positive.[539] He was originally charged with attempted murder in addition to felonious assault.[540]

- An HIV-positive man pleaded guilty for failing to disclose his HIV status to his sexual partner.[541] He was originally sentenced to ten years imprisonment for felonious assault and for possessing cocaine.[542]

- In 2009, an HIV-positive man was sentenced to seven years imprisonment for failing to disclose his HIV status to his sexual partner. The man appealed his conviction arguing that he did not know his HIV status and could therefore not be convicted under the statute. The court reasoned that because the defendant had discussed his HIV-positive status with detectives, there was sufficient evidence to show that he knew his HIV status despite the fact that there was no medical record that the defendant had tested positive for HIV.[543]

- In 2006, an HIV-positive man was convicted of nine counts of felonious assault for exposing his sexual partner, who was under the age of 18-years-old and not his wife, to

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[537] Felonious assault statutes also apply to persons who "knowingly cause physical harm to another." OHIO REV. CODE ANN. § 2903.11(A)(1)(1996) A woman was convicted of attempted felonious assault for biting a hospital employee who was trying to restrain her. State v. Reif-Hill, 1998 WL 787389 (Ohio Ct. App. 1998). Prior to the assault she had told the hospital staff that she had AIDS though she did not. On appeal the court vacated the conviction and ordered the release of the defendant because the prosecution failed to prove that the defendant knowingly caused or attempted to cause serious physical harm to the victim by biting him with the intent to pass on HIV. Because the defendant did not have HIV and the victim did not contract HIV the conviction was vacated.

[538] Tom Giambroni, *Husband Allegedly kept HIV a secret*, MORNING JOURNAL, Oct. 2, 2010, available at http://www.morningjournalnews.com/page/content.detail/id/526618/Husband-allegedly-kept-HIV-a-secret.html?nav=5006

[539] Gabriel Baird, *Man who gave wife AIDS gets five years in prison*, THE PLAIN DEALER, March 8 2010, *available at* http://blog.cleveland.com/metro/2010/03/man_who_gave_wife_aids_gets_5.html.

[540] Gabriel Baird, *Woman hopes tale can warn others after husband conceals illness*, THE PLAIN DEALER, February 28, 2010 *available at* http://blog.cleveland.com/metro/2010/02/oman_hopes_she_can_warn_others.html

[541] State v. Jones, 2009 WL 4811329 (Ohio Ct. App. 2009).

[542] *Id.* at 3.(vacating and remanding because the state failed to live up to its plea negotiations of recommending the defendant to a term of imprisonment of two to four years.).

[543] State v. Russell, No. 09AP-226, 2009 WL 3090190 (Ohio Ct. App. Sept. 29, 2009).

HIV.[544] He was sentenced to four years imprisonment and forced to register as a sex offender.[545]

- An HIV-positive man was sentenced to four years imprisonment for abduction and six years for felonious assault for failing to tell his sexual partner that he was HIV-positive.[546] The trial court ordered that the sentences be served consecutively. On appeal, the court found that the trial court's determination of consecutive sentencing was proper because the defendant may have transmitted HIV to the complainant and because it was unclear how many other people the defendant may have exposed to HIV through unprotected sex.

- An HIV-positive man was sentenced to four years in jail under felonious assault charges for failing to tell his sexual partner that he was HIV-positive.[547]

- An HIV-positive man pleaded guilty to two counts of felonious assault and was sentenced to twelve years imprisonment for failing to tell his sexual partners about his HIV status.[548]

- In 2008, an HIV-positive man was charged with felonious assault for failing to disclose his HIV status to his sexual partner.[549]

After being released from prison for felonious assault charges, HIV-positive persons may be subject to invasive parole and community control standards. In 2006, an HIV-positive man was sentenced to two years imprisonment for failing to tell his sexual partner that he was HIV-positive.[550] A year later he was released and put on community control for five years. As part of his community control, the defendant could "have no sexual conduct with any individual without prior approval of the court."[551] During his community control, the defendant engaged in two sexual relationships, one with a man and one with a woman, both of whom knew of his HIV status, but only one of them (the woman) had received court approval. In the trial regarding whether the defendant had violated his community control sanctions by engaging in sexual relationship with the man without court approval the trial court found the defendant guilty and sentence him to two years imprisonment.

On appeal, the defendant argued that he did not violate the court's orders because (1) he and the man never had sex; (2) even if they had a sexual relationship the man knew about the defendant's HIV status; and (3) that it was an unconstitutional invasion of his right to privacy to require court approval for potential sex partners. The Ohio Court of Appeals was "concerned" about the breadth

[544] State v. Christian, No. 07 JE 9, 2007 WL 4696853 (Ohio Ct. App. Dec. 28, 2007).
[545] A sex offender is classified as someone who is convicted of or pleads guilty to a sexually oriented offense. Felonious assault, when committed with a sexual motivation is a sexually oriented offense. Ohio Rev. Code Ann. § 2950.01(G)(1)(c)(West 2010). The court in this case found that because the defendant knew he was HIV positive and engaged in sexual conduct with a person under 18 years old, who was not his spouse, such conduct had a sexual motivation and therefore was a sexual oriented offense. The court upheld the defendant's sexual offender status.
[546] State v. Greiger, No. 22073, 2004 WL 3017314 (Ohio Ct. App. Dec. 22, 2004).
[547] State v. Roberts, 805 N.E.2d 594 (Ohio Ct. App. 2004).
[548] Tracey Reed, *Man gets 6 more years in HIV-Case*, NEWS-HERALD NEWS, Sept. 6, 2008, *available at* http://news-herald.com/articles/2008/09/06/news/doc48c208d20292e286892120.txt.
[549] Dana Wilson, *Man who hid HIV status charged with Assault*, COLUMBUS DISPATCH, June 30, 2008, *available at* http://www.dispatch.com/live/content/local_news/stories/2008/06/30/ayala_hiv.html?sid=101.
[550] State v. Eversole, 912 N.E. 2d 643 (Ohio Ct. App. 2009).
[551] *Id.* at 644.

of the community control requiring court approval for sexual partners but found that the defendant failed to timely appeal the right to privacy issue and would therefore not address it.[552] The court overruled the defendant's other issues on appeal, finding that the trial court was correct in monitoring the defendant's activities to "protect the public from the blatant disregard [the defendant] demonstrated when he failed to disclose his condition to the initial victim of his offense."[553] The court held that the defendant was in violation for failing to tell the trial court about his sexual relationship with man despite the fact that the man had full knowledge of defendant's HIV status.

HIV-positive persons can face criminal penalties for prostitution and solicitation of prostitution.

It is a third-degree felony for HIV-positive persons to solicit (advertising the illegal sale of sex for hire) or encourage another to solicit prostitution.[554] It is a felony in the fifth degree for an HIV-positive person to "loiter to engage in prostitution."[555] For HIV-negative persons the charge is a misdemeanor in the third degree.[556]

A person "loiters to engage in prostitution" when a she/he tries to stop another person, engages or attempts to engage another in conversation, stops or attempts to stop the operator of a car, or approaches a stationary car with the intent to engage in sexual activity for hire while in or near a public place.[557] A person can also be charged with loitering to engage in prostitution if she/he is the driver or passenger in a car and tries to do any of the aforementioned activities or entice another person to approach or enter the vehicle with the purpose of engaging in sexual activity for hire.

Under this statute it does not matter whether any sexual act was performed, if there was any possibility of transmitting HIV, or if there was an intent to transmit HIV. The mere discussion of engaging in sexual conduct for money is sufficient for prosecution. In *State v. McPherson*[558], the appellant was found guilty of solicitation of prostitution while HIV-positive and was sentenced to three years imprisonment and forced to register as a sex offender. McPherson was charged when he approached an undercover officer, who knew that the McPherson was HIV-positive and had been previously arrested for solicitation. The two engaged in conversation and when McPherson agreed to perform a sexual act for $10 he was arrested.

On appeal, the Ohio Court of Appeals addressed whether there was sufficient evidence to convict McPherson of solicitation, if McPherson knew of his HIV-positive status, and whether the trial court correctly forced him to register as a sex offender. The court found that because the defendant initiated the conversation with the undercover officer and was the first person to discuss sex and money there was enough evidence to successfully prosecute him for solicitation despite the fact that no sexual act or exchange of money had occurred. On the question of whether the defendant knew

[552] *Id.* at 646.
[553] *Id.* at 647.
[554] OHIO REV. CODE ANN. §§ 2907.24, 2907.25 (West 2010).
[555] OHIO REV. CODE ANN. § 2907.241(B) (West 2010).
[556] § 2907.241(D)(1).
[557] § 2907.241(A).
[558] 758 N.E.2d 1198 (Ohio Ct. App. 2001).

his HIV-positive status, the court concluded that the medical records noting the defendant's status and the police department's vice squad's knowledge of the defendant's status was sufficient to prove that McPherson knew he was HIV-positive. The court reversed the finding that the defendant had to register as a "sex offender" because solicitation is not considered a sexually oriented offense.

Other examples of prosecutions for solicitation and prostitution after an HIV-positive test include:

- An HIV-positive woman was convicted of two counts of soliciting another to engage in sexual activity for hire after a positive HIV test.[559] She was sentenced to four years imprisonment, each charge to be served concurrently.
- In 2000, an HIV-positive man was convicted of solicitation while being HIV-positive and was sentenced to two years imprisonment.[560]
- A 25-year-old HIV-positive man was arrested for attempted solicitation of prostitution while knowing he was HIV-positive.[561]
- In 2010, an HIV-positive woman was charged with solicitation after testing positive for HIV.[562]
- In 2003, a woman was sentenced to two years imprisonment for solicitation after testing positive for HIV.[563]

HIV-positive persons face penalties for exposing others to any bodily fluid.

Under Ohio's harassment by inmate statute HIV-positive persons can face third-degree felony charges for exposing any other person to their urine, feces, saliva, blood, or any other bodily substance with the intent to annoy, threaten, alarm, or harass.[564] Though the statute is named "harassment by inmate" a person does not have to be imprisoned or in confinement to be prosecuted under this statute.

HIV-positive persons face increased sentences despite the fact that many of the bodily substances at issue present no risk risks of transmitting HIV. Urine, feces, and saliva are not known transmitters of HIV but despite these facts HIV-positive persons can face five years imprisonment for exposing others to these fluids while HIV-negative persons only face a maximum of one year imprisonment. Many of the cases under this statute arise from people spitting at or throwing urine at law enforcement officials. Neither act is known to transmit HIV.

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[559] State v. West, No. 22966, 2009 WL 4268554 (Ohio. Ct. App. Nov. 25, 2009).
[560] State v. Jones, No. 19978, 2004 WL 690419 (Ohio Ct. App. Apr. 2, 2004).
[561] Lucas Sullivan, *HIV-Positive Man Arrested in Sting*, DAYTON DAILY NEWS (Ohio), Sept. 12, 2009, at A6.
[562] John Futty, *Woman faces multiple counts of soliciting with HIV*, COLUMBUS DISPATCH, July 31, 2010, at B03.
[563] John Futty, *Prostitute's HIV status overlooked in charges,* COLUMBUS DISPATCH, September 12, 2010 *available at* http://www.dispatch.com/live/content/local_news/stories/2010/09/12/prostitutes-hiv-status-overlooked-in-charges.html?sid=101.
[564] OHIO REV. CODE ANN. §2921.38(c)(West 2010).

In *State v. Thompson*, the HIV-positive defendant was a prisoner at the Southern Ohio Correctional Facility ("SOCF") and threw a cup full of feces at a nurse employed by SOCF.[565] The feces hit her in the face, hair, arms, chest and leg. The defendant was brought before the Rules Infraction Board at SOCF was sentenced to fifteen days in disciplinary control. He was also indicted on two counts of harassment by an inmate. The defendant moved to dismiss on the grounds of double jeopardy, and the trial court overruled the motion. The defendant later pleaded no contest to one count and was sentenced to an additional nine months imprisonment.

The defendant appealed his conviction, contending that the disciplinary proceedings at the SOCF were criminal in nature, and that his subsequent conviction for harassment by an inmate violated the double jeopardy provisions of the U.S. Constitution. The appellate court sustained the defendant's conviction, finding that the legislature intended that the administrative sanctions imposed upon an inmate by prison authorities to be civil in nature and that the subsequent criminal action did not violate the Double Jeopardy Clause. If one is imprisoned and convicted under the harassment by inmate statute she/he may face penalties implemented by the prison system as well as additional sentences forced by the courts.

In *State v. Lewis*, an HIV-positive man was found guilty of nine counts of third-degree felony harassment by an inmate charges, one count of intimidation by a public servant, and was sentenced to twenty years imprisonment.[566] The appellant denied he was HIV-positive and though the state produced medical records stating that the appellant had been diagnosed in 1996 those medical records had not been given to the appellant during the discovery phase of the trial. The appellant argued at trial that he needed to obtain exculpatory lab tests proving that he was HIV-negative and asked for a continuance, which was denied, to prepare this defense. On appeal the Ohio Court of Appeals found that the trial court abused its discretion by admitting the medical records on the first day of the trial before the defendant had time to prepare a defense and rebut the prosecution's assertion that he was HIV-positive. The conviction was reversed and the case remanded.

Other prosecutions and cases under the harassment by inmate statute include:

- In 2010, a 41-year-old, HIV-positive man was charged with harassment by an inmate, among other charges, for spitting in the eye of an officer after trying to break into a convenience store.[567]

- A 48-year-old, HIV-positive man was charged with two counts of harassment by an inmate for spitting at a police officer.[568]

The CDC has long maintained that saliva, urine, and feces are not means of transmitting HIV.[569]

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[565] 726 N.E.2d 530 (Ohio Ct. App. 1999).
[566] State v. Lewis, No. 07CA3137, 2008 WL 787722 (Ohio Ct. App. March 21, 2008).
[567] *Akron Police Say Man Spit on Officer, Store Break-In Suspect says he's HIV positive*, AKRON BEACON JOURNAL, Feb. 17, 2010 at B10.
[568] *Police: Man with AIDS Spits on Officer*, NEWS 5 WLWT.COM, Aug. 12, 2009, *available at* http://www.wlwt.com/news/20368401/detail.html?taf=cin.
[569] Centers for Disease Control and Prevention, *HIV Transmission* (Mar. 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm.

HIV-positive persons are prohibited from donating or selling blood or plasma.

It is a felony, punishable by up to eighteen months imprisonment, for an HIV-positive person to donate or sell her/his blood, plasma, or any other blood product.

HIV-positive persons have been incarcerated for using saliva as a "deadly weapon."
Ohio's felonious attempt statute, in addition to prosecuting persons for failing to disclose their HIV status to sexual partners, has also been used to prosecute HIV-positive persons for using their saliva or other bodily fluid as a "deadly weapon."[570] Under the felonious assault statute, "no person shall knowingly [...] cause or attempt to cause physical harm to another or another's unborn by means of a deadly weapon."[571] In multiple cases, Ohio courts have determined that any spit of an HIV-positive person containing a mixture of blood and saliva is a "deadly weapon."

In *State v. Price*, the appellant, an HIV-positive hemophiliac, spat at and bit a police officer.[572] He was indicted on one count of felonious assault, one count of attempted felonious assault, and one count of assault on a peace officer. He was sentenced to six years imprisonment because the court found that his spit and saliva constituted a deadly weapon.[573]

On appeal, the appellant argued that his spit and saliva should not be considered a deadly weapon. A "deadly weapon" is defined as "any instrument, device, or thing capable of inflicting death, and designed or specially adapted for use as a weapon, or possessed, carried, or used as a weapon."[574] During the trial the defendant's treating physicians testified that though there is only a remote risk of transmitting HIV via saliva, because the defendant is a hemophiliac, his saliva would have blood in it a majority of the time and as such there would be a potentially high concentration of the HIV virus. The Ohio Court of Appeals determined, based on this testimony, that because the appellant was HIV-positive and a hemophiliac, his saliva was a deadly weapon. The court reasoned that the appellant was correctly convicted under the felonious assault statute because he knew about his illness, knew that "his saliva was a deadly weapon," and still assaulted the officer.[575]

In a similar case, *State v. Branch*, the HIV-positive defendant spit in the eye of a police officer and was arrested for felonious assault and attempt.[576] He was sentenced to four years imprisonment. At trial there was evidence to suggest that the spit may have contained blood. The medical examiner testified that there was a small risk of getting HIV from spitting when the saliva contains blood but that saliva alone is not "a significant risk factor in transmitting HIV."[577] On appeal, the defendant argued that he could not be convicted under the statute because the risk of spitting in the officer's eye was negligible.

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[570] State v. Bird, 692 N.E.2d 1013 (Ohio 1998)(the HIV-positive defendant pleaded no contest to felonious assault charges for spitting in the eye of a police officer and was sentenced to three to fifteen years imprisonment).
[571] OHIO REV. CODE ANN. § 2903.1(a)(2)(West 2010).
[572] 834 N.E. 2d 847 (Ohio Ct. App. 2005).
[573] *Id.*
[574] OHIO REV. CODE ANN. § 2923.11(a)(West 2010)
[575] *Price*, 834 N.E.2d at 849.
[576] 2006 WL 2045911 (Ohio Ct. App. 2006)
[577] State v. Branch, 2006 WL 2045911, *1 (Ohio Ct. App. 2006).

In order to convict defendant of attempted felonious assault, the prosecution was required to prove that appellant attempted to knowingly "cause or attempt to cause physical harm to another [...] by means of a deadly weapon or dangerous ordnance" and that the defendant engaged in "conduct that, if successful, would constitute or result in the offense."[578] The court determined that even if it was factually or legally impossible under the circumstances for the appellant transmit HIV to the officer, it is no defense if the act could have been completed had the circumstances been as the appellant believed. The court upheld the conviction, finding that the appellant intended to harm the officer and because his saliva was mixed with blood it could be considered a deadly weapon.

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[578] OHIO. REV. CODE. ANN. §§ 2923.11(a), 2923.02(A)(West 2010)

Oklahoma Statute(s)[579] that Allow for Criminal Prosecution based on HIV Status:

OKLA. STAT. TIT. 21, § 1192.1

Knowingly engaging in conduct likely to transfer HIV virus

It shall be unlawful for any person knowing that he or she has Acquired Immune Deficiency Syndrome (AIDS) or is a carrier of the human immunodeficiency virus (HIV) and with intent to infect another, to engage in conduct reasonably likely to result in the transfer of the person's own blood, bodily fluids containing visible blood, semen, or vaginal secretions into the bloodstream of another, or through the skin or other membranes of another person, except during in utero transmission of blood or bodily fluids, and:

1. The other person did not consent to the transfer of blood, bodily fluids containing blood, semen, or vaginal secretions; or

2. The other person consented to the transfer but at the time of giving consent had not been informed by the person that the person transferring such blood or fluids had AIDS or was a carrier of HIV.

Any person convicted of violating the provisions of this section shall be guilty of a felony, punishable by imprisonment in the custody of the Department of Corrections for not more than five (5) years.

OKLA. STAT. TIT. 21, § 1031

Knowingly engaging in prostitution while infected with HIV

Any person who engages in an act of prostitution with knowledge that they are infected with the human immunodeficiency virus shall be guilty of a felony punishable by imprisonment in the custody of the Department of Corrections for not more than five (5) years.

[579] Oklahoma also has a felony communicable disease statute that penalizes exposure to venereal diseases. However, this statute was enacted long before HIV and there has never been a prosecution against an HIV-positive person under the statute. "It is a felony for any person, after becoming infected with a venereal disease and before being pronounced cured by a physician in writing, to marry any other person or to expose any other person by the act of copulation or sexual intercourse to such venereal disease or to liability to contract the venereal disease." OKLA. STAT. TIT. 63, § 1-519(1967). "Venereal disease" means any disease which may be transmitted from any person to any other through or by means of sexual intercourse and found and declared by medical science or accredited schools of medicine to be infectious or contagious. OKLA. STAT. TIT. 63, § 1-517(1963).

HIV-positive persons can face felony charges for failing to disclose their HIV-status to their sexual partners.

It is punishable by up to five years in prison for HIV-positive persons to engage in conduct that carries a "reasonable likelihood" of transmitting HIV, with the intent to infect another. For prosecution the complainant must not have agreed to engage in such conduct or must not have known of the HIV-positive person's status. HIV transmission is not required for conviction.

Although Oklahoma's HIV exposure statute requires intent to transmit HIV, prosecutions under this statute have resulted in convictions even if there was no indication that the defendant acted with intent to transmit HIV but only failed to inform her/his sexual partner about her/his HIV status:

- In 2009, a 40-year-old HIV-positive man was arrested and charged with HIV exposure for failing to tell a man that he had HIV before engaging in oral sex.[580]

- A 20-year-old woman was charged under Oklahoma's exposure statute solely because she allegedly failed to inform her partner that she was HIV-positive.[581]

- A 41-year-old HIV-positive man was charged with engaging in conduct likely to transfer HIV for failing to disclose his HIV status to his sexual partner.[582]

The common element in all of these cases was the defendant's apparent failure to disclose her/his HIV status to sex partners.

Disclosure is an affirmative defense to prosecution under this statute but it is important to note that even when a person does disclose her/his HIV status it can be difficult to prove such disclosure in court. In these matters, relying on party testimony has inherent. For example, an HIV-positive man was charged with knowingly spreading HIV to his girlfriend, who asserted that she did not know the man's status over the period of their relationship.[583] It wasn't until six months after the initial charges were brought that detectives determined, due to the testimony of witnesses, that the woman had in fact been aware of the man's HIV status before starting their sexual relationship.

The statute does not carve out a specific defense based on the use of a condom or other protection during penile-vaginal, anal, or oral sex, nor has the use of a condom or low viral load been relied upon as a defense in any currently-available reported case decisions in Oklahoma.

HIV-positive persons have been prosecuted under Oklahoma's criminal HIV exposure law for spitting and biting.

Oklahoma's HIV exposure statute creates criminal liability for "conduct reasonably likely to result in the transfer of the person's own blood, bodily fluids containing visible blood, semen, or vaginal

[580] *Oklahoma City man arrested on suspicion of transmitting AIDS*, NEWSOK, August 27 2009, available at http://newsok.com/man-arrested-on-suspicion-of-transmitting-aids/article/3396100?custom_click=rss
[581] *Enid woman will be arraigned next week on felony charge that she exposed a former love to HIV*, AP ALERT, June 8, 2004.
[582] *Man Faces HIV Charge*, OKLAHOMAN, March 26, 2003, at 2.
[583] *Authorities Drop Charges Against HIV-Positive Man*, TULSA WORLD, Oct. 1, 1992, at C12.

secretions into the bloodstream of another, or through the skin or other membranes of another person."[584] HIV-positive individuals have been charged with HIV exposure for acts, such as biting and spitting, that have only theoretical or remote risks of transmission of HIV and that contravene the actual requirements of the statutes:

- In May 2010, a man claiming to be HIV-positive was booked on four felony complaints of spreading an infectious disease and knowingly engaging to transfer HIV after slinging his head to throw blood at emergency medical workers. He is also alleged to have spit at the workers during his rescue.[585]

- A 50-year old, HIV-positive woman was arrested in October 2008 and charged with engaging in conduct likely to transfer HIV after biting a security guard.[586]

In both of the above cases, the risk of HIV transmission is remote at best. The CDC has concluded that there exists only a "remote" possibility that HIV could be transmitted through a bite and such transmission would have to involve various aggravating factors including "severe trauma, extensive tissue damage, and the presence of blood."[587] The CDC has also concluded that spitting alone has never been shown to transmit HIV.[588] The application of Oklahoma's statute ignores these scientific findings, leading to prosecutions for behavior that has at best a remote possibility of transmitting HIV.

Engaging in sex work while HIV-positive can lead to enhanced penalties of up to five years in jail.

Upon conviction for prostitution, sex workers face up to five years in prison if they know they are HIV-positive. This specifically targets HIV-positive persons regardless of whether they intended to transmit HIV, transmitted the virus, or engaged in activities likely or possible to do so. On the face of this statute, no actual sexual activity is required to face felony prosecution.

HIV-positive persons have also been convicted under general criminal laws.

Though Oklahoma enacted its HIV exposure statute in 1997, there has been at least one case of HIV exposure since that time that has been prosecuted under general criminal laws. In 2000, a 41-year-old, HIV-positive man pleaded guilty to fifty-six counts of sexual abuse and one count of attempted murder after he engaged in sexual intercourse with two female minors.[589] Each count represented a month that he engaged in sexual conduct with one or both of the minors. The

[584] OKLA. STAT. TIT. 21, § 1192.1 (West 2010).
[585] Shannon Muchmore, *Man Who Says He Has HIV Allegedly Spits on Emergency Workers*, TULSA WORLD, May 23, 2010, http://www.tulsaworld.com/news/article.aspx?subjectid=11&articleid=20100523_298_0_Amanwh547994.
[586] Jay Marks, *HIV-positive Woman Faces Felony for Bite,* NEWSOK, Oct. 8, 2008, http://newsok.com/hiv-positive-woman-faces-felony-for-bite/article/3308838.
[587] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission, Can HIV be transmitted through a Human Bite?,* (March 25, 2010), http://www.cdc.gov/hiv/resources/qa/transmission.htm.
[588] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission, Can HIV be transmitted by being spit on by an HIV infected person?,* (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm.
[589] Bill Braun, *Tulsa Man Imprisoned for Life on Sex Counts*, TULSA WORLD, May 24, 2000, at A13

attempted murder charge arose from allegations that he knew he was HIV-positive and repeatedly engaged in unprotected sex with one of the minors, who later became pregnant and both she and her baby tested positive for HIV. The other minor tested negative for HIV. The defendant was sentenced to four consecutive life sentences and fifty-three concurrent life sentences.

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Oregon Statute(s) that Allow for Criminal Prosecution based on HIV Status:

No specific statute on record.

Persons with HIV have been prosecuted for HIV exposure under the general criminal laws.

There are no statutes explicitly criminalizing HIV transmission or exposure in Oregon, however, Oregon has prosecuted HIV-positive persons for exposing others to HIV under general criminal laws, including attempted murder, assault, and reckless endangerment. Failing to disclose HIV status to sexual partners may result in prosecution and conviction.

In *State v. Hinkhouse*, an HIV-positive defendant was convicted of ten counts of attempted murder and ten counts of attempted assault when he failed to disclose his HIV status to numerous sexual partners, including a 3-year old girl that he sexually abused.[590] The defendant had refused to use a condom with several sexual partners and denied being HIV-positive, despite being warned by his parole officer not to have unprotected sex.[591] According to the testimony of one sexual partner, the defendant said that if he ever became HIV-positive, he would spread the virus to others.[592] At least one of the defendant's partners was infected with HIV though this fact was irrelevant to prosecution.[593] He was sentenced to seventy years in prison.[594]

On appeal, the defendant argued that he did not intend to kill his sexual partners, only to gratify himself sexually.[595] The Court of Appeals of Oregon disagreed, finding that the defendant's refusal to wear condoms, failure to disclose his HIV status, and awareness of the risks of unprotected sex were all sufficient to prove intent to cause harm or death.[596] The court also found that Hinkhouse's unsafe sexual practice was not only for his own sexual gratification because he did use condoms with the one woman that he planned to marry. Before his attempted murder conviction, the defendant also served eleven months in prison for recklessly endangering two women by engaging in unprotected sex and sexually abusing a 15-year old girl.[597]

In 1993, another HIV-positive man in Oregon was convicted of assault and reckless endangerment when two of his sexual partners tested positive for HIV.[598] He was sentenced to three years in prison, registered as a sex offender, and was forbidden from going into bars, contacting victims, contacting girls without written permission, and having unprotected sex with an HIV-negative person. He later received seven years in prison for exposing a Canadian woman to HIV in 1996. It is not known whether the man used condoms during sex or disclosed his status.

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[590] State v. Hinkhouse, 912 P.2d 921 (Or. Ct. App. 1996), *adhered to as modified*, 915 P.2d 489 (Or. Ct. App. 1996); Rick Bella, *Jury Finds Hinkhouse Used HIV as Weapon*, OREGONIAN, Mar. 16, 1994, at B01.
[591] *Hinkhouse*, 912 P.2d at 923.
[592] *Id.*
[593] *Id.* at 922.
[594] Josh Meyer, *Non-Unanimous Jury Idea Appeals to Some Reformers*, L.A. TIMES, Sept. 28, 1994, at 12.
[595] *Hinkhouse*, 912 P.2d at 922.
[596] *Id.* at 925
[597] *New Charges Face Man Infected with AIDS Virus*, OREGONIAN, Nov. 2, 1993, at B03.
[598] Ann Saker, *More Jail for Fugitive Sex Offender*, OREGONIAN, Dec. 8, 2005, at B01.

Individuals living with HIV in Oregon should be aware that they risk criminal liability if they fail to disclose their HIV status to sexual partners or engage in unprotected sex. The two cases above concern the rare and extreme instances when HIV-positive individuals repeatedly failed to disclose their HIV status, refused to use condoms or other protection. In *Hinkhouse*, the defendant's long history of failing to tell his partners about his HIV status and refusal to wear condoms certainly went to the court's determination of specific intent but the facts of the case could have been more appropriately applied to a charge of reckless endangerment.

HIV-positive status may also be a factor in sentencing. In *State v. Guayante*, an HIV-positive defendant was convicted on several counts of sexual abuse of a 13-year old girl.[599] On appeal, he argued that it would be disproportionately harsh to use his HIV-positive status as an "aggravating factor" during sentencing. The Court of Appeals of Oregon disagreed stating the defendant's willingness to expose his victim to HIV infection was a valid aggravating factor to consider when imposing maximum, consecutive sentences for sexual assault. Given that the defendant in *Guayante* exposed a girl to the *risk* of HIV infection, neither the intent to transmit HIV nor actual HIV transmission is required for aggravated factor sentencing.

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[599] State v. Guayante, 783 P.2d 1030, 1031 (Or. Ct. App. 1989).

Pennsylvania Statute(s) that Allow for Criminal Prosecution based on HIV Status:

18 PA. CONS. STAT. ANN. § 2703

Assault by prisoner

A person confined in any jail, prison, or correctional or penal institution is guilty of a felony of the second degree if he/she, while confined (or while being transported to or from such a facility), intentionally or knowingly causes another to come into contact with blood, seminal fluid, saliva, urine or feces by throwing, tossing, spitting or expelling such fluid or material when, at the time of the offense, the person knew, had reason to know, or should have known or believed that such fluid or material was infected by a communicable disease, including, but not limited to, HIV or hepatitis B.

The court shall order that any sentence imposed for a violation of this section and subsection §2702(a) (related to aggravated assault), where the victim is a detention facility or correctional facility employee, be served consecutively with the person's current sentence.

Violation of this statute shall be a second degree felony.

18 PA. CONS. STAT. ANN. §2704

Assault by life prisoner

Every person sentenced to death or life imprisonment who intentionally or knowingly causes another to come into contact with blood, seminal fluid, saliva, urine or feces by throwing, tossing, spitting or expelling such fluid or material when, at the time of the offense, the person knew, had reason to know, or should have known or believed that the fluid or material was infected with HIV, is guilty of a crime, the penalty for which shall be the same penalty for murder of the second degree.

18 PA. CONS. STAT. ANN. § 5902

Prostitution while HIV-positive

It is a felony of the third degree for a person to commit prostitution knowing he or she is HIV-positive; to knowingly promote prostitution of one who is HIV-positive; or, if the person knows him or herself to be HIV-positive, to patronize a prostitute.

18 PA. CONS. STAT. ANN. §§ 1103, 1101

Sentence of imprisonment for Felonies

Second degree felony: a term which shall be fixed by the court at not more than ten years.

Third degree felony: a term which shall be fixed by the court at not more than seven years.

Fines for Felonies

First or second degree felony: $25,000.

Third degree felony: $15,000.

HIV-positive persons have been convicted under Pennsylvania's general criminal laws for various types of conduct, including failing to disclose their HIV status to their sexual partners.

Although Pennsylvania does not have a specific criminal HIV-exposure law to address non-incarcerated persons and those who are not sex workers, numerous persons have been prosecuted for HIV exposure under general criminal laws, including murder, attempted murder, and reckless endangerment.

In Pennsylvania, HIV-positive persons have been prosecuted for failing to disclose their HIV status to their sexual partners. In the 2006 case, *Commonwealth v. Cordoba*, a man was charged with reckless endangerment for having unprotected, consensual oral sex and failing to disclose to his partner that he was HIV-positive.[600] The trial court ruled that because consent is not a defense to reckless endangerment, to prosecute an HIV-positive individual for engaging in consensual sex would lead to absurd results, including prosecution even if the person did disclose her/his status.[601]

[600] Commonwealth v. Cordoba, 2004 WL 3322620, at *1 (Pa. Com. Pl. 2004), *overruled by* Commonwealth v. Cordoba, 902 A.2d 1280 (Pa. Super. 2006).

[601] The court found that "[U]nder the Commonwealth's theory, even if an HIV-positive individual informs his or her partner of this status prior to engaging in unprotected sexual activity, the statute would still be violated. A person carrying an infectious disease would commit a crime every time he/she had consensual sex. This is an absurd result, as individuals in this Commonwealth are free to make such intimate decisions outside the glare of state scrutiny. Lastly, allowing an HIV-positive individual to be prosecuted under this statute for allegedly having consensual sexual contact with another adult would open the floodgates to jilted lovers and angry spouses to file charges after a relationship has soured."[601] *Id.* On appeal, the Superior Court did not address this issue because it was outside of the scope of the case and was not at issue because the defendant never disclosed his status. Commonwealth v. Cordoba, 902 A.2d 1280, 1286 (Pa. Super. 2006).

On appeal the Superior Court of Pennsylvania reversed the trial court's findings. Though there was never any transfer of blood or semen that could result in HIV transmission (the defendant only ejaculated on the face and chest of the complainant, however, HIV has been found in pre-seminal fluids),[602] the court found that the sex was not consensual and amounted to reckless endangerment because the defendant failed to disclose his HIV status to the complainant.[603] Reckless endangerment under Pennsylvania law is defined as "conduct which places or may place another person in danger of death or serious bodily injury."[604] Even though most exposure to the blood or semen of an HIV-positive person will not result in transmission, the court determined that the prosecution need only establish that the defendant's conduct placed "*or may have placed*" another in danger of serious bodily injury or death.[605]

To establish a *prima facie* case for reckless endangerment, the court found that there only needs to be a possibility of the risk of harm, regardless of the likelihood of that harm actually occurring. According to the court, the defendant's actions constituted a "gross deviation from the standard of conduct that a reasonable person would observe" by engaging in oral sex without informing the complainant of his HIV status.[606]

The statute does not explicitly provide for a defense based on use of condoms, or other protection, or a low viral load (amount of active HIV virus in an individual's bloodstream) even though both significantly reduce the risk of HIV transmission to near zero.

Though disclosing one's HIV status is a defense to this type of prosecution, disclosure of HIV status is difficult to prove in court without witnesses or documentation, and juries often consider the testimony of HIV-positive defendants less credible than the testimony of HIV-negative persons claiming that they were exposed to HIV without consent.

In addition to reckless endangerment, HIV-positive individuals have also been charged with murder and attempted murder for failing to disclose their HIV-positive status to their sexual partners:

- In 1999, a 30-year-old man is charged with murder, attempted homicide and aggravated assault for failing to tell five female sex partners that he had HIV.[607] Each of the women allegedly tested positive for HIV after engaging in sexual conduct with the man.[608] The man died in 2000 before the case could go to trial.[609]
- In 1996, an HIV-positive man received twenty years to life in prison for sexually assaulting a

[602] *Cordoba*, 902 A.2d at 1283 (Pa. Super. 2006)
[603] *Id.* at 1286.
[604] *Cordoba,* 18 PA. CONN. STAT. ANN. § 2705 (West 2010).
[605] 902 A.2d at 1289.(emphasis not added).
[606] *Id.*(quoting 18 PENN. CON. STAT. ANN. § 302(b)(3)).
[607] Jeff Gelman, *AIDS-Related Death Leads to 3rd-Degree Murder Charge*, MORNING CALL (Allentown, PA), Nov. 20, 1999, at A03.
[608] *Id.*
[609] Debbie Garlicki, *Man Who Allegedly Infected with AIDS Virus Dies*, MORNING CALL (Allentown, PA), Dec. 1, 2000 *available at* http://articles.mcall.com/2000-12-01/news/3330315_1_aids-virus-infected-murder-charge.

12-year old girl, after which she tested positive for HIV. [610]

- In 1992, a 50-year old man with AIDS was arrested after he allegedly paid several hundred Philadelphia boys for their sexual favors, underwear, and feces.[611] The man's bail was increased to $20 million after it was disclosed that he was HIV-positive.[612] He died before the trial.[613]
- In *Commonwealth v. Bey*[614], the court affirmed the ten to twenty year sentence of the single count of a deviate sexual intercourse due in part to the defendant's HIV-positive status. The court reversed the trial court's determination that the defendant was a sexual predator.

In *Commonwealth v. Walker*, an HIV-positive man was found guilty of communicating terrorist threats when he scratched a parole officer on the hand and said, "I have open cuts on my hands. Life is short. I am taking you with me."[615] The officer knew Walker was HIV-positive. On appeal, Walker argued that the evidence against him was insufficient and that he didn't have the requisite intent to terrorize the officer. To be convicted of making terroristic threats one must communicate a threat to terrorize another or act with reckless disregard of the risk of causing terror. The court affirmed the conviction finding that the jury could have inferred that Walker's statements intended to cause terror from fear of HIV infection. The court held that the likelihood of HIV infection from scratching was immaterial to the case as long as the threats were made with the intent to cause such fear.

Other prosecutions of HIV-positive persons under Pennsylvania's general criminal laws have included convictions for acts that are not known to transmit HIV:

- A 39-year old, HIV-positive man was charged with aggravated assault and was sentenced to thirteen years and six month to twenty-seven years in prison in 1999 for biting a security guard who was arresting him for shoplifting. The guarded tested negative for HIV. [616]
- In October 2009, a 34-year-old HIV and Hepatitis C-positive woman was charged for aggravated assault after she spat in the face of another inmate. She was later sentenced to

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[610] Jeff Gelman, *AIDS-Related Death Leads to 3rd-Degree Murder Charge*, MORNING CALL (Allentown), Nov. 20, 1999, at A03.
[611] Michael DeCoury Hinds, *Man Who Has Aids May Have Infected Hundreds of Boys*, MORNING CALL (Allentown, PA), Mar. 28, 1992, at A02.
[612]U.S. ex Rel. Savitz v. Gallagher, 800 F.Supp. 288 (E.D. Pa. 1992); Barnaby C. Wittels & Stephen Robert LaCheen, *The Persecution of Ed Savitz*, PHILA. INQUIRER, May 12, 1993, at A11; *see also* Lynne M. Abraham, *Ed Savitz was No Victim, No Icon of Virtue*, PHILA. INQUIRER, June 1, 1993, at A13; *What Has Savitz Case Taught Us?*, PHILA. DAILY NEWS, Mar. 30, 1993.
[613] Lee Linder, *Sex Charges Dropped Against Savitz but Alleged Victims Sue Dead Man's Estate*, MORNING CALL (Allentown, PA), Apr. 6, 1993, at A05.
[614] 841 A.2d 562 (Pa. Super Ct. 2004)
[615] 836 A.2d 999 (Pa. Super. Ct. 2003).
[616] Debbie Garlicki, *City Man with HIV Virus Gets Prison Time for Biting*, MORNING CALL (Allentown, PA), Feb. 4, 1999, *available at* http://articles.mcall.com/1999-02-04/news/3240187_1_infected-human-immunodeficiency-virus-police-officer; Laura Whitehorn, *America's Most Unwanted*, POZ, Aug. 2000, http://www.poz.com/articles/204_10206.shtml..

twenty-one months to ten years imprisonment.[617]

- In 1997, a 32-year old HIV-positive woman was arrested and charged with attempted murder after she allegedly stabbed a CVS employee with a syringe, claiming the syringe was infected with HIV. [618]
- In *Commonwealth v. Brown*[619], a defendant, who was HIV-positive and had Hepatitis B, was convicted of aggravated assault for throwing fecal matter on a guard's face.

Many of these convictions are based on the stigma and fear surrounding HIV and not on the science of how HIV is transmitted.

HIV-positive persons who are incarcerated face increased penalties for exposing others to their bodily fluids, including saliva.

The Pennsylvania HIV exposure statute for incarcerated persons is overly broad and criminalizes conduct that does not in fact transmit HIV. Under the statute, if a person in confinement intentionally causes another person to "come into contact with blood, seminal fluid, saliva, urine or feces by throwing, tossing, spitting or expelling such fluid or material" and "the person knew, had reason to know, or should have known or believed that such fluid or material was infected by a communicable disease, including, but not limited to, HIV"[620] that person can face an additional sentence of up to ten years in prison.[621] The CDC has long maintained that there is no risk of transmission from saliva, urine, or feces unless there is contamination with infected blood.

If the incarcerated person is already serving a life sentence or is on death row and violates the statute then that person will be prosecuted for second-degree murder.

It is a felony for people who are HIV-positive to engage in or solicit prostitution.

A person is guilty of prostitution while HIV-positive if she/he is part of a house of prostitution, engages in sexual activity as a business, or loiters in or within view of any public place for the purpose of being hired to engage in sexual activity.[622]

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[617] Michael Rudolf, *HIV-Positive Prisoner Sentenced for Spitting at Inmate*, CITIZENSVOICE.COM, Oct. 15, 2009, http://citizensvoice.com/news/hiv-positive-prisoner-sentenced-for-spitting-at-inmate-1.335692; Josh Mrozinski, *Inmate Charged for Assault for Spiting*, WCEXAMINER.COM (Wyoming County, Pa.), Jan. 14, 2009, http://wcexaminer.com/sections/news/archive/2009/01/14/inmate-charged-with-assault-for-spitting.aspx.
[618] Thomas J. Gibbons Jr., *Syringe-Attack Case in Suspect's Second*, PHILA. INQUIRER, Jan. 17, 1997, at B03.
[619] 605 A.2d 429 (Pa. Super. Ct. 1992).
[620] The statute was rewritten in 1998 to include "HIV" after the 1992 conviction of inmate, who tested positive and been counseled for both HIV and Hepatitis B, for throwing urine and feces at a prison guard. *See* Commonwealth v. Brown, 605 A.2d 429 (Pa. Super. Ct. 1992). The defendant was convicted of aggravated assault, assault by prisoner, simple assault, and reckless endangerment and sentenced to ten to twenty years in prison to run consecutively with the sentence he was already serving. The court found that because the defendant knew he had both HIV and Hepatitis B and threw the fecal matter at a guard, that was sufficient to produce "serious bodily injury" and sustain a conviction for Assault by Prisoner. *Id.* at 431.
[621] 18 PA. CONS. STAT. §§ 5902(a), 1103 (West 2010).
[622] § 5902(A).

Sexual activity for the purposes of the statute is broadly defined as "sexual intercourse for hire" and "includes homosexual and other deviate sexual relations."[623] The lack of a clear definition of "sexual acts" in the statute has led the Pennsylvania courts to attempt to define what types of sexual acts are punishable under the prostitution statute.[624] Many of the acts that the courts have found to be criminally liable "sexual acts" pose no risk of transmitting HIV, including acts that do not involve penetration of the body[625] or the transfer of blood or semen, such as massaging another person's genitals[626] and giving a hand job or fingering.[627] This broad definition of "sexual acts" poses the risk of severe penalties for HIV-positive sex workers who engage in conduct that does not transmit HIV.

Disclosure of one's HIV status, the use of condoms or other protection, or the sex worker's viral load are not considered a defense to prosecution. This creates a situation where HIV-positive person are prosecuted and suffer increased penalties due to their HIV-status alone and not to the risk they pose of transmitting HIV.

The punishment for HIV-positive sex workers is significantly harsher than the punishment for sex workers who do not test positive for HIV. Prostitution is normally punished under varying degrees of misdemeanors that range from a few months to a few years imprisonment, based on the number of prior convictions.[628] However, if a sex worker is HIV-positive she/he is subject to third-degree felony charges, punishable by up to seven years in prison.[629]

Examples of prosecutions under this statute include:

- In January 2009, a 26-year old sex worker pleaded guilty to reckless endangerment and engaging in prostitution while HIV-positive. She received three years probation.[630]

- In 1996, an HIV-positive sex worker was charged with engaging in prostitution while being HIV-positive.[631] Another HIV-positive sex worker was convicted of the same offense in 1998, and sentenced to seven years imprisonment.[632]

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, should not be used as a substitute for legal advice.

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[623] § 5902(A), (F).
[624] *See* Commonwealth v. Bleigh, 586 A.2d 450 (Pa. Super. Ct. 1991).
[625] Commonwealth v. Lundberg, 37 Pa. D. & C.3d 4 (Pa. Ct. Com. Pl. 1985).
[626] Commonwealth v. Cohen, 538 A.2d 582, 583 (Pa. Super. Ct. 1988).
[627] *Id.*
[628] 18 PA. CONS. STAT. ANN. § 5902(A.1)(WEST 2010). Prostitution charges that are non-HIV specific are normally prosecuted as either first, second, or third degree misdemeanors that range in maximum sentences from one to five years imprisonment. 18 PA. CONS. STAT. ANN. § 1104 (WEST 2010)
[629] § 5902 (A.2).
[630] Laurie Mason, *HIV-positive Prostitute Sentenced*, BUCKS COUNTY COURIER TIMES (Philadelphia, PA), Jan. 16, 2009, at 1.
[631] David Kinney, *Authorities Crack Down on HIV-Positive Prostitutes*, PHILA. INQUIRER, Aug. 17, 1996, at B03.
[632] April Adamson, *Obscure Law Used on Reckless Hookers*, PHILA. DAILY NEWS, June 16, 1998, at 8.

Rhode Island Statute(s) that Allow for Criminal Prosecution based on HIV Status:

No specific statute on record.

Rhode Island has a communicable disease control statute but this statute has not targeted HIV exposure.

Rhode Island does have a general sexually transmitted disease (STD) exposure statute. It is an offense punishable by up to $100 or three months in prison for an individual with an STD to knowingly expose another to infection.[633] However, this law was enacted long before HIV was discovered and thus not originally intended to address HIV. There has never been an arrest or prosecution for HIV exposure under this or any other statute in Rhode Island.

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[633] R.I. GEN. LAWS § 23-11-1 (1921) (imposing penalties for knowing exposure to sexually transmitted diseases including, but not be limited to, syphilis, gonorrhea, chancroid, granuloma inguinale and lymphogranuloma venereum).

South Carolina Statute(s) that Allow for Criminal Prosecution based on HIV Status:

S.C. Code Ann. § 44-29-145

Penalty for exposing others to HIV

It is unlawful for a person who knows he or she is infected with HIV to: (1) knowingly engage in sexual intercourse (vaginal, anal, or oral) with another person without first informing that person of his HIV infection; (2) knowingly commit an act of prostitution with another person; (3) knowingly sell or donate blood, blood products, semen, tissue, organs, or other body fluids; (4) forcibly engage in sexual intercourse (vaginal, anal, or oral) without the consent of the other person, including one's legal spouse; or (5) knowingly share with another person a hypodermic needle/syringe without first informing that person that the needle or syringe has been used by someone infected with HIV.

Any person convicted under this statute is guilty of a felony, resulting in imprisonment up to ten years and/or a maximum fine of $5,000.

S.C. Code Ann. §§ 44-29-60, 44-29-140

Penalties Pertaining to Venereal Disease

It is unlawful for anyone infected with an STD included in the annual SC Department of Health and Environmental Control List of Reportable Diseases to knowingly expose another to infection. ("HIV" was included in the DHEC list for 2009.)

Any person in violation of this statute has committed a misdemeanor. Persons will be subject to a fine of not more than $200 and imprisoned for not more than thirty days.

HIV-positive persons face criminal penalties for engaging in sexual activity without disclosing their HIV status.[634]

It is felony, punishable by a fine of no more than $5,000 and/or imprisonment for up to ten years, for a person who is aware that she/he is HIV-positive to knowingly engage in penile-vaginal, anal, or

[634] Though there is a separate misdemeanor penalty for exposing people to venereal diseases, including HIV, S.C. CODE ANN. §§ 44-29-60, 44-29-140, this statute is not in practical effect for HIV exposure prosecutions as there is an HIV-specific statute for HIV exposure, S.C. CODE ANN. § 44-29-145. There does not appear to be any HIV cases prosecuted under the venereal disease statute.

oral sex with another person without first informing that person of her/his HIV status. Neither actual transmission nor the intent to transmit HIV is necessary for prosecution.

On its face, the statute does not recognize the use of protection, such as condoms, or low viral load as defenses to prosecution. Under the terms of the statute, even if HIV-positive persons protect their sexual partners by using a condom, they must also disclose their status to avoid application of the statute.

In South Carolina there have been numerous prosecutions of HIV-positive individuals for engaging in consensual sex but who allegedly failed to disclose their HIV status:

- An HIV-positive man who failed to disclose his HIV status and engaged in unprotected, consensual sex with a female partner was charged with exposing another to HIV.[635]

- An HIV-positive man was sentenced to six years in prison and four years of probation for knowingly exposing his wife to HIV.[636] She did not test positive for HIV and maintained that she had no knowledge that her husband was HIV-positive.

- A 40-year-old HIV-positive man pleaded guilty to knowingly exposing his ex-girlfriend to HIV and was sentenced to four and a half years imprisonment.[637] Investigators claim that the man never told the woman he was HIV-positive nor did he insist on using condoms. The woman learned she was HIV-positive during a pre-natal checkup for the twins that the man fathered. But the woman's HIV status was irrelevant to the charges.

- A 35-year-old HIV-positive man was charged with exposing another to HIV after he failed to disclose his HIV status to his sexual partner with whom he engaged in consensual, unprotected sex.[638]

Though disclosure is an affirmative defense to prosecution in South Carolina, whether or not disclosure actually occurred is often open to interpretation and always depends on the word of one person against another.

General criminal laws have been used to prosecute HIV-positive persons for alleged HIV exposure.

In a recent South Carolina case, a 41-year-old HIV-positive man was charged with assault and intent

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[635] *Athens police say man may have deliberately spread HIV*, AUGUSTA CHRONICLE, Apr. 17, 2010, available at http://chronicle.augusta.com/news/crime-courts/2010-04-17/athens-police-say-man-may-have-deliberately-spread-hiv
[636] Stephanie Toone, *Former Aiken County teacher found guilty of exposing others to HIV*, AUGUST CHRONICLE, Nov. 13, 2009, available at http://chronicle.augusta.com/stories/latest/lat_703284.shtml
[637] *Man Knowingly Exposed Woman to HIV*, WYFF4.COM, Feb. 2, 2009, *available at* http://www.wyff4.com/r/18623886/detail.html
[638] *Deputies: Man illegally exposes victim to HIV virus*, WMBFNEWS.COM, Sept. 11, 2009, *available at* http://www.wmbfnews.com/Global/story.asp?S=11115609

to kill after biting his neighbor.[639] The original charge of simple assault was upgraded to intent to kill after it was discovered that the defendant was HIV-positive.[640] The CDC has long maintained that spitting alone has never been shown to transmit HIV.[641]

HIV-positive persons can be fined and imprisoned if convicted of prostitution.

In South Carolina a person who is aware that she/he is HIV-positive may be criminally liable for committing an act of prostitution, facing penalties of up to ten years in prison and/or be subject to a $5,000 fine. In contrast, prosecutions for HIV-negative sex workers have penalties limited to ninety days to one year in prison and a fine of a few hundred dollars.[642] By the mere fact of being HIV-positive, sex workers are subject to more than ten times greater penalties than their HIV-negative counterparts. In addition to disproportionate penalties for HIV-positive sex workers, South Carolina's HIV exposure statute potentially targets activities that pose no risk of HIV transmission.

Prostitution is defined as "engaging or *offering* to engage in sexual activity with or for another in exchange for anything of value."[643] Under this definition, the mere offer of a sexual act could result in imprisonment under the HIV exposure statute even when there is no risk of HIV transmission. And even if the offered act was completed there is no consideration about whether the activities posed a risk of HIV exposure or transmission (i.e.: an HIV-positive sex worker performing oral sex has a remote possibility of HIV exposure/transmission because saliva is not a means to transmit HIV).

The term "sexual activity" for a prostitution charge, and subsequent HIV exposure prosecution, has a broad definition and includes many acts that pose no risk of transmitting HIV. Under the original HIV exposure statute, S.C. CODE ANN. § 44-29-145, prosecutions were limited to penile-vaginal sex, anal sex, and oral sex. However, for prostitution prosecutions "sexual activity" includes, but is not limited to, acts of masturbation; touching a person's clothed, or unclothed, genitals or breasts; and other acts such as using sex toys.[644] These activities pose absolutely no risk of HIV transmission but HIV-positive sex workers may face felony charges for engaging in them. It is not a defense if condoms or other protection were used during sexual activity or if HIV status was disclosed.

HIV-positive persons are can face criminal penalties for donating blood, organs, human tissue, semen, or other body fluids.

It is felony, punishable by a fine of no more than $5,000 and/or imprisonment for up to ten years, for a person who is aware that she/he is HIV-positive to knowingly donate or sell blood, semen, tissue, organs or other bodily fluids. Neither the intent to transmit HIV nor actual transmission is required for liability.

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[639] Greg Suskin, *Charges Upgraded Against HIV Positive Man After Fight,* WSOCTV.COM, July 23, 2009, http://www.wsoctv.com/news/20147162/detail.html
[640] *Id.*
[641] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission, Can HIV be transmitted by being spit on by an HIV infected person?,* (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm.
[642] S.C. CODE ANN. § 16-15-110 (2010).
[643] § 16-15-375(4).
[644] § 16-15-375(5).

HIV-positive persons can be prosecuted and jailed for sharing dirty syringes with others.

It is felony, punishable by up to ten years imprisonment and/or a maximum fine of $5,000 for a person who is aware that she/he is HIV-positive and knowingly share equipment used for injecting drugs with another without disclosing her/his HIV status.

HIV-positive persons in South Carolina should not share, or exchange, or otherwise transfer to any other person unsterilized needles used to inject substances into the human body. Simply giving someone a dirty syringe is sufficient for a conviction; neither the intent to transmit HIV nor actual transmission is required.

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South Dakota Statute(s) that Allow for Criminal Prosecution based on HIV Status:

S.D. CODIFIED LAWS § 22-18-31

Class 3 Felony: Intentional exposure to HIV infection

Any person who, knowing himself or herself to be infected with HIV, intentionally exposes another person to infection through any of the following means is guilty of criminal exposure to HIV (Class 3 felony):

(1) Engaging in sexual intercourse or other intimate physical contact with another person;

(2) Transferring, donating, or providing blood, tissue, semen, organs, or other potentially infectious body fluids or parts for transfusion, transplantation, insemination, or other administration to another in any manner that presents a significant risk of HIV transmission; or

(3) Dispensing, delivering, exchanging, selling, or in any other way transferring to another person any nonsterile intravenous or intramuscular drug paraphernalia that has been contaminated by himself or herself; or

(4) Throwing, smearing, or otherwise causing blood/semen to come in contact with another for the purpose of exposing that person to HIV infection.

"Intimate physical contact" means bodily contact which exposes a person to the body fluid of the infected person in any manner that presents a significant risk of HIV transmission. S.D. CODIFIED LAWS § 22-18-32(2).

"Intravenous or intramuscular drug paraphernalia" means any equipment, product, or material of any kind which is peculiar to and marketed for use in injecting a substance into the human body. S.D. CODIFIED LAWS § 22-18-32(3).

It is an affirmative defense to prosecution if it is proven by a preponderance of the evidence that the person exposed to HIV knew that the infected person was infected with HIV, knew that the action could result in infection with HIV, and gave advance consent to the action with that knowledge. S.D. CODIFIED LAWS § 22-18-33.

The actual transmission of HIV is not required. S.D. CODIFIED LAWS § 22-18-34.

S.D. CODIFIED LAWS § 22-6-1

Felony classes and penalties

Class 3 felony: maximum fifteen years imprisonment in the state penitentiary. In addition, a fine of $30,000 may be imposed.

Engaging in sexual intercourse without disclosing HIV status can result in imprisonment

In South Dakota, failing to disclose HIV status to sexual partners may result in imprisonment. It is a Class 3 felony punishable by a maximum of fifteen years in prison[645] if an individual aware that she/he is HIV-positive intentionally exposes another to infection through sexual intercourse or "other intimate physical contact."[646] A $30,000 fine may also be imposed.[647] Sex offender registration is mandatory.[648] "Intent" for the purposes of this statute requires a specific design to expose another to HIV or an intent to engage in the prohibited activities under the statute.[649]

Neither the intent to transmit HIV nor actual transmission is required.[650]

An individual prosecuted under this exposure law has a defense that may prevent conviction if she/he can prove that the person exposed to HIV (1) was aware of her/his HIV status, (2) knew that the sexual contact could result in HIV infection, and (3) consented to HIV exposure with knowledge of these risks.[651] However, a sexual partner's consent to HIV exposure may be difficult to prove as whether or not disclosure occurred is often open to interpretation and always depends on the words of one person against another.

Engaging in unprotected sex while HIV-positive can result in imprisonment. In South Dakota's first prosecution for HIV exposure, an HIV-positive college student received 120 days in jail and 200 hours of community service[652] after he had unprotected sex with several classmates without disclosing his HIV status.[653] Under the terms of his guilty plea, the man was also ordered to abstain from unprotected sex unless he notified partners that he was HIV-positive.[654] He later received four years in prison for failing to return to jail on schedule.[655]

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645 S.D. CODIFIED LAWS § 22-6-1(6) (2005).
646 § 22-18-31(1) (2005).
647 § 22-6-1(6)(2005).
648 *See* S.D. CODIFIED LAWS § 22-24B-1(20) (West 2010) (defining intentional HIV exposure as a sex crime); S.D. CODIFIED LAWS § 22-24B-2 (West 2010) (requiring sex offender registration for any person convicted of a se x crime).
649 § 22-1-2(1)(b)(West 2010).
650 § 22-18-34 (2000).
651 § 22-18-33 (2005).
652 Jo Napolitano, *South Dakota: Jail Term for H.I.V. Exposure,* N.Y. TIMES, Aug. 30, 2002, at A-15.
653 John W. Fountain, *After Arrest, Campus Queues for H.I.V. Tests*, N.Y. TIMES, May 1, 2002, at A-16, *available at* http://www.nytimes.com/2002/05/01/us/after-arrest-campus-queues-for-hiv-tests.html; *see also* John-John Williams, *2 S. Dakotans Sentenced for Spreading HIV*, ARGUS LEADER (Sioux Falls, SD), Mar. 26, 2003, at 1B; Leslie E. Wolf, *Crime and Punishment: Is There a Role for Criminal Law in HIV Prevention Policy?*, 25 WHITTIER L. REV. 821, 863-65 (2004).
654 Jo Napolitano, *supra* note 679.
655 Leslie E. Wolf, *supra*, at 863-65.

The following cases serve as further examples of prosecutions that may result under South Dakota law:

- In August 2005, a 26-year old, HIV-positive man was arrested and charged with several counts of intentional exposure to HIV after he allegedly lied about his HIV status to multiple sexual partners. [656]
- In November 2006, an HIV-positive woman received a suspended prison sentence after she exposed several sexual partners to HIV. [657] None of the woman's partners were infected but this is irrelevant to prosecution.
- In May 2002, two HIV-positive partners in a gay couple were indicted for exposing several sexual partners to HIV.[658] In March 2003, one of the men pleaded guilty, receiving forty-five days in jail and five years probation. [659] The outcome of his partner's case is unknown.
- In March 2003, a 30-year old, HIV-positive woman received three months imprisonment and five years probation for intentionally exposing a sexual partner to HIV. She was also ordered to abstain from unprotected sex and submit to lie detector tests when requested. [660]

Consecutive, as opposed to concurrent, sentencing is allowed at the discretion of a sentencing court in South Dakota.[661] Thus, if an HIV-positive person is found guilty of exposing multiple partners to the virus, it is possible for her/him to receive a sentence of fifteen years *per* offense.

It is a felony to provide blood, tissue, semen, organs, body parts, or body fluids for use by another.

In South Dakota, imprisonment may also result from donating bodily fluids or tissues. It is a Class 3 felony, punishable by up to fifteen years in prison,[662] if an individual aware that she/he is HIV-positive intentionally exposes another to infection by transferring, donating, or providing blood, tissue, semen, organs, or other "potentially infectious bodily fluids" for use by another.[663] Specifically, fluids or tissues may not be provided for "transfusion, transplantation, insemination, or other administration to another in any manner that presents a significant risk of HIV transmission."[664] A $30,000 fine may also be imposed. [665]

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[656] Denise Tucker, *Inmate May Have Spread HIV*, ARGUS LEADER (Sioux Falls, SD), Aug. 6, 2005, at 1B.
[657] *Woman with HIV Sentenced*, RAPID CITY J. (Rapid City, SD), Nov. 4, 2004, http://www.rapidcityjournal.com/news/local/article_59a9d4d6-bfc3-511b-98b9-106b8fb035b8.html.
[658] Rhonda Smith, *S.D. gay couple faces prison for exposing others to HIV*, WASH. BLADE, May 24, 2002, http://www.aegis.org/NEWS/wb/2002/WB020512.html.
[659] John-John Williams, *supra* note 279.
[660] *Id.*
[661] S.D. CODIFIED LAWS § 22-6-6.1(1939).
[662] § 22-6-1(6).
[663] § 22-18-31(2).
[664] § 22-18-31(2).

Neither the intent to transmit HIV nor actual transmission is required.[666]

An individual prosecuted for HIV exposure has an affirmative defense if she/he can prove that the individual exposed to HIV (1) was aware of her/his HIV-positive status, (2) knew that HIV infection could result from the exposure in question, and (3) consented to exposure with knowledge of these risks.[667]

Sharing non-sterile needles or syringes can result in imprisonment.

South Dakota's "intentional exposure" laws explicitly prohibit HIV-positive drug users from sharing used needles and syringes. It is a Class 3 felony for an individual aware that she/he is HIV-positive to intentionally expose another to infection by dispensing, delivering, exchanging, selling, or in any other way transferring to another any non-sterile "intravenous or intramuscular drug paraphernalia" that she/he has contaminated.[668] In South Dakota, Class 3 felonies are punishable by up to fifteen years in prison and possibly a $30,000 fine.[669]

Neither the intent to transmit HIV nor actual transmission is required.[670]

Under the terms of this statute, "intravenous or intramuscular drug paraphernalia" is defined as any equipment, product, or material of any kind which is peculiar to and marketed for use in injecting a substance into the human body.[671] To avoid prosecution, HIV-positive drug users should not share needles, syringes, or any other devices used to inject drugs into the body. Presumably, if these items are sterilized before transfer to another, prosecution may be avoided. However, it may be difficult to prove that a needle or syringe was sterile at the time of transfer to another without witnesses or documentation.

An individual prosecuted under this needle-sharing law has a defense if she/he can prove that the individual exposed to HIV (1) was aware of her/his HIV-positive status, (2) knew that HIV infection could result from sharing drug paraphernalia, and (3) consented to exposure with knowledge of these risks. However, an individual's consent to HIV exposure may also be difficult to prove without documentation.[672]

Exposing the body of another person to blood or semen can result in imprisonment.

In South Dakota, it is also a Class 3 felony, punishable by a maximum of fifteen years in prison,[673] if an individual aware that she/he is HIV-positive intentionally exposes a person to HIV infection by

[665] § 22-6-1(6).
[666] § 22-18-34.
[667] § 22-18-33.
[668] § 22-18-31(3).
[669] § 22-6-1(6).
[670] § 22-18-34.
[671] § 22-18-32(3).
[672] § 22-18-33.
[673] § 22-6-1(6).

throwing, smearing, or otherwise causing blood or semen to come in contact that person.[674] A $30,000 fine may also be imposed.[675]

Actual transmission of HIV is not required.[676] An individual will only be prosecuted under this prong of South Dakota's HIV exposure laws if she/he acted with the purpose of exposing another to HIV infection. This reduces the risk that HIV-positive persons will be prosecuted for accidentally exposing others to their bodily fluids. However, it is important to note that cases concerning the intent or purpose to spread HIV sometimes hinge on uncorroborated testimony from prison guards, police, or assault victims claiming they were attacked by HIV-positive persons attempting to infect them.[677]

No individual in South Dakota has been prosecuted for throwing or "smearing" blood or semen on another.

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, should not be used as a substitute for legal advice.

[674] § 22-18-31(4).
[675] § 22-6-1(6).
[676] § 22-18-34.
[677] *See, e.g.,* Stephanie Ramage, *Too Lenient?*, SUNDAYPAPER.COM, Aug. 30, 2009, http://www.sundaypaper.com/More/Archives/tabid/98/articleType/ArticleView/articleId/4452/Too-lenient.aspx (reporting on a 2008 Georgia case, where an officer bitten by an HIV-positive man during a confrontation claimed that the man screamed "I have full-blown AIDS … You're going to die."); *but see* Marvin S. Arrington, *Judge Marvin S. Arrington responds to the Sunday Paper*, SUNDAYPAPER.COM, Oct. 4, 2009, http://www.sundaypaper.com/More/Archives/tabid/98/articleType/ArticleView/articleId/4572/Default.aspx (explaining that a state patrol police report had no mention of the alleged threat, even though a threat of HIV infection would clearly be an important piece of information for such a report. Records may actually suggest that the HIV-positive man only said "I'm HIV positive."); *see also* Idaho, Michigan, Massachusetts.

Tennessee Statute(s)[678] that Allow for Criminal Prosecution based on HIV Status:

TENN. CODE ANN. § 39-13-109

Criminal Exposure of another to HIV

It is unlawful for a person, knowing that he or she is infected with HIV, to knowingly:

(1) engage in intimate contact with another;
(2) transfer, donate or provide any potentially infectious body fluid or part for administration to another person in any manner that presents a significant risk of HIV transmission; or
(3) transfer in any way to another any nonsterile intravenous or intramuscular drug paraphernalia.

"Intimate contact with another" means the exposure of the body of one person to a bodily fluid of another person in any manner that presents a significant risk of HIV transmission.

It is an affirmative defense, if proven by a preponderance of the evidence, that the person exposed to HIV knew the infected person was infected with HIV, knew the action could result in infection with HIV, and gave advance consent to the action with that knowledge. The actual transmission of HIV is not a required element of this offense.

Violation of this statute is a class C felony punishable by three to fifteen years imprisonment and a possible fine of up to $10,000. TENN. CODE. ANN. § 40-35-111.

TENN. CODE ANN. § 39-13-516

Aggravated Prostitution

A person commits aggravated prostitution when, knowing that such person is infected with HIV, the person engages in sexual activity as a business or in a house of prostitution or loiters in a public place for the purpose of being hired to engage in sexual activity. Actual transmission of HIV is not a required for prosecution. Violation of this statute is a class C felony punishable by three to fifteen years imprisonment and a possible fine of up to $10,000. TENN. CODE. ANN. § 40-35-111.

[678] It is a class C misdemeanor, punishable by a fine of no more than $50 and/or imprisonment for no more than thirty days, for a person who is aware that she/he is infected with a sexually transmitted disease (including HIV) to knowingly expose another to that sexual transmitted disease by any means. TENN. CODE ANN. §§ 68-10-107, 68-10-101. However, because there is a specific HIV exposure statute it is unlikely that an HIV-positive person would be prosecuted under this statute.

TENN. CODE ANN. § 39-13-108

HIV; Willful Transmission; Quarantine

The department of health, acting pursuant to § 68-10-109, shall promulgate rules regarding transmission of human immunodeficiency virus (HIV). The rules shall include specific procedures for quarantine or isolation, as may be necessary, of any person who clearly and convincingly demonstrates willful and knowing disregard for the health and safety of others, and who poses a direct threat of significant risk to the health and safety of the public regarding transmission of HIV. The department is authorized to quarantine or isolate a person within a secure facility, after exercising other appropriate measures, if the person continues to pose a direct threat of significant risk to the health and safety of the public. Any person so quarantined or isolated within a secure facility, who intentionally escapes from the facility, commits a Class E felony.

TENN. CODE ANN. § 40-35-114(21)

Enhancement Factors

If the defendant is convicted of the offenses of aggravated rape pursuant to § 39-13-502, rape pursuant to § 39-13-503, rape of a child pursuant to § 39-13-522, or statutory rape pursuant to § 39-13-506, the defendant knew or should have known that, at the time of the offense, the defendant was HIV positive, the court shall considered this as an advisory factor in determining whether to enhance the defendant's sentence.

HIV-positive persons may face criminal penalties for engaging in sexual activities without disclosing their HIV status.

In Tennessee, it is against the law for a person who is aware that she/he is HIV-positive to engage in "intimate contact" with another without first disclosing her/his HIV status. Intimate contact is defined as any contact between the body of one person and the bodily fluids of another person in a manner that presents a significant risk of HIV transmission. Actual transmission of HIV is not necessary for a conviction.

Violating this statute is a Class C felony, punishable by three to fifteen years imprisonment as well as a possible $10,000 fine. If an HIV-positive person is convicted under this statute she/he will also have to register as a sex offender.[679]

[679] TENN. CODE ANN. § 40-39-202(28) (2004).

If HIV-positive persons disclose their HIV status to sexual partners prior to engaging in activities that present a significant risk of HIV transmission is an affirmative defense. Proving disclosure can be challenging because there are rarely documents or other incontrovertible proof of disclosure and these cases often result in the defendant and complainant's versions of the story pitted against one another.

In *State v. Smith*, there was a discrepancy between the defendant's and complainant's evidence regarding whether or not the defendant had disclosed his HIV status.[680] The defendant, who was charged with criminal exposure to HIV, among other charges, testified that he told the complainant that he had HIV and assumed that the complainant had used a condom before they engaged in anal sex. The defendant maintained that he discovered later that the complainant had not used the condom. The complainant testified otherwise, noting that though the sex was consensual, the defendant never disclosed his HIV status and the complainant only found out the information from a friend afterwards.

Tennessee's criminal exposure statute requires that there be "exposure" of bodily fluids between an HIV-positive person and another that presents a significant risk of transmission, but the scope of such exposure is not defined in the statute. In *State v. Bonds*, the Tennessee Court of Appeals defined "exposure" to encompass acts that presented a risk of transmission but declined to require an exchange of bodily fluids.[681] The HIV-positive defendant in that case was sentenced to six years for criminal exposure of HIV and an additional twenty-five years for aggravated rape.[682] On appeal, the defendant argued that under the terms of the HIV exposure statute he never "exposed" the complainant to HIV because there was no proof that there had been any exchange of bodily fluids during the commission of the crime.[683]

The court determined that actual exposure to body fluids was not required but rather "the prosecution need only show that the defendant subjected the victim to the risk of contact with the [d]efendant's bodily fluids[...] in a manner that would present a significant risk of HIV transmission."[684] Because the defendant knew of his HIV status and anally raped the victim, the court found that this presented a significant risk of HIV transmission punishable under the HIV exposure statute.[685] After reviewing previous cases of HIV exposure in Tennessee, the court in *Bonds* found successful prosecutions hinged on the fact that the sex was unprotected and undisclosed, increasing the possible "risk" of transmitting HIV – as opposed to if a condom or other protection had been used.[686]

The prosecutions of HIV exposure involving "intimate contact" in Tennessee appear to be limited to cases where the HIV-positive defendant did not disclose her/his HIV status and a condom or other protection was not used during sexual intercourse. Other prosecutions of criminal exposure to HIV involving intimate contact include:

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[680] State v. Smith, No. M2007-00932-CCA-R10-CO, 2008 WL 544603, at *1 (Tenn. Crim. App. May 5, 2008).
[681] State v. Bonds, 189 S.W.3d 249 (Tenn. Crim. App. 2005).
[682] *Id.*
[683] *Id.* at 257.
[684] *Id.* at 258.
[685] *Id.*
[686] *Id.* at 259.

- In October 2010, an HIV-positive man was charged with four counts of criminal exposure of HIV after allegedly having sex with at least two women.[687]

- A 24-year-old HIV-positive defendant was sentenced to fourteen years for HIV exposure and an additional six years for statutory rape for having unprotected sex with a 14-year-old. The defendant never told the minor that he was HIV-positive.[688]

- The HIV-positive defendant pleaded guilty to twenty-two counts of criminal exposure to HIV and was sentenced to twenty-six years and six months imprisonment.[689] The defendant engaged in unprotected sex with multiple men without disclosing her HIV status. Though the defendant maintained that she told her partners about her HIV status, the complainants testified otherwise. The men maintained that the defendant purposefully denied her HIV status and they did not use condoms. After ten years imprisonment the defendant was released and is currently on parole for twelve years.[690]

- A 31-year-old HIV-positive defendant pleaded guilty to criminal exposure to HIV and was sentenced to five concurrent four-year sentences. The defendant engaged in five consensual, unprotected sexual encounters with the same female and did not disclose his status.[691]

- In October 1999, an HIV-positive defendant pleaded guilty to nine counts of criminal exposure to HIV and three counts of statutory rape. He was sentenced to seventeen years imprisonment.[692] The defendant failed to disclose his HIV status, and when asked by his sexual partners, denied that he had HIV.[693] At least two of the women that he was intimate with tested positive for HIV but that did not matter for the purposes of the charges or prosecution.[694]

- In June 1999, a man was charged with statutory rape and criminal exposure to HIV.[695]

Though the most of the prosecutions for HIV exposure in Tennessee involve unprotected sexual activity without disclosure of HIV status, there have been multiple cases of arrests and prosecutions for criminal exposure to HIV that presented only a remote risk of transmission of HIV:

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[687] Claire Galofaro, *"Flipper" Sensabaugh indicted on charges of criminal exposure to HIV*, TRICITIES.COM, Oct. 29, 2010, http://www2.tricities.com/business/2010/oct/29/flipper-sensabaugh-indicted-charges-criminal-expos-ar-614364/
[688] State v. Harvey, No. W2001-01164-CCA-R3-CD, 2002 WL 1162346, at *1 (Tenn. Crim. App. May 31, 2002).
[689] State v. Wiser, No. M1999-02500-CCA-R3-CD, 2000 WL 1612363, at *2 (Tenn. Crim. App. Oct. 30, 2000).
[690] *Woman who spread HIV leaves prison*, TIMES GAZETTE, Dec. 31, 2008, available at http://www.t-g.com/story/1489830.html.
[691] State v. Bennett, No. 03C01-9810-CR-00346, 1999 WL 544653, at *1 (Tenn. Crim. App. July 28, 1999).
[692] Jones v. Carlton, No. E2008-01737-CCA-R3-HC, 2008 WL 5204434, at *1 (Tenn. Crim. App. Dec. 11, 2008) (citing State v. Jones, No. E1999-01296-CCA-R3-CD, 2001 WL 30198, at *1 (Tenn. Crim. App. Jan. 12, 2001)).
[693] *Jones*, 2001 WL 30198, at *1.
[694] *Id.*
[695] *Man Allegedly Shot Girlfriend in front of Son*, DAILY NEWS JOURNAL, June 28, 1999, at X.

- In September 2009, an HIV-positive man was charged with criminal exposure to HIV, among other offenses, for spitting blood on an officer during a robbery.[696]

- In November 2010, a man was charged with aggravated assault and criminal exposure of another to HIV for allegedly spitting on a detention officer.[697] At the time of the charges there was no evidence to prove that the man was in fact HIV-positive.

- A 34-year-old HIV-positive man was indicted on charges of criminal exposure to HIV for allegedly spitting on a police officer.[698]

HIV-positive persons who engage in prostitution face enhanced criminal penalties.

It is a Class C felony, punishable by three to fifteen years in prison for an HIV-positive person who knows her/his status to engage in acts of prostitution.[699] Conviction under this statute also results in the defendant having to register as a sex offender.[700] Actual transmission of HIV is not required for conviction. A conviction for prostitution in a case not involving HIV is a Class B misdemeanor punishable by no more than a six month sentence and/or a $500 fine, but an HIV-positive defendant faces a thirty times greater penalty for the same offense. [701]

Under the statute, it is not required that an act that could transmit HIV occur for conviction. It is not a consideration whether condoms or other protection were used or if the HIV-positive defendant had a low viral load.

There are approximately thirty-nine women in Tennessee who have been convicted of aggravated prostitution.[702]

One's HIV status may also be considered an aggravating factor in sentencing.

Tennessee's sentencing enhancement notes that if a defendant knew her/his HIV status during the commission of an aggravated rape, sexual battery, rape of a child, or statutory rape, the sentencing court may consider the defendant's HIV status in sentencing.[703] In order to sustain a sentence enhancement under this provision, the defendant must have known her/his HIV status during the

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[696] Shane Myers, *HIV Positive Burglary Suspect Spits Blood on Memphis Police Officer*, Sept. 3, 2009, available at http://www.myeyewitnessnews.com/news/local/story/HIV-Positive-Burglary-Suspect-Spits-Blood-on/bRidZPpqH06j3lInPJIenw.cspx. Case outcome is unknown.
[697] *Inmate charged with exposing jailer to HIV*, WKRN.COM, Nov. 8, 2010, http://www.wkrn.com/Global/story.asp?S=13466403; Chris Graham, *Family Disputes HIV Charge*, THE DAILY HERALD, Nov. 10, 2010, http://www.c-dh.net/articles/2010/11/09/top_stories/01thomason.txt.
[698] *HIV Case Accused of Spitting At Cop*, MEMPHIS COMMERCIAL APPEAL, July 22, 1998, at B2.
[699] TENN. CODE ANN. § 39-13-516 (2010).
[700] § 40-39-202(20)
[701] § 39-13-513; § 40-35-111.
[702] J.J. Stambaugh, *HIV-positive Knoxville woman a walking felony*, knoxnews.com, June 30, 2009 http://www.knoxnews.com/news/2009/jun/30/hiv-positive-knoxville-woman-a-walking-felony/
[703] TENN. CODE ANN. § 40-35-114(21) (2008).

commission of the assault. In *State v. Banks*, Tennessee Court of Criminal Appeals vacated a trial court's imposing consecutive sentencing for a defendant convicted of aggravated kidnapping and rape because there was no trial court finding to show that the defendant knew his HIV status during the offense.[704] The defendant was originally sentenced to two twenty-three year consecutive sentences, for a total of forty-six years imprisonment.

Donating blood, organs, tissue, semen, or other body fluids is prohibited.

HIV-positive persons must not donate or sell blood or any other body parts meant for transfer to another person. Actual transmission of HIV is not necessary for a conviction and a violation of this statute could result in up to fifteen years imprisonment.

HIV-positive persons may be criminally prosecuted for sharing needles.

A person who is aware that she/he is HIV-positive may be criminally liable for providing another person with any non-sterile equipment used for injecting drugs that has been used by an HIV-positive person. Actual transmission of HIV is not necessary for a conviction.

Important note: While we have made an effort to ensure that this information is current, the law is always changing and we cannot guarantee the accuracy of the information provided. This information may or may not be applicable to your specific situation and, as such, it should not be used as a substitute for legal advice.

[704] 2010 WL 1486897 (Tenn. Crim. App. 2010).

Texas Statute(s) that Allow for Criminal Prosecution based on HIV Status:

No specific statute on record.

Though there is no explicit HIV criminal transmission statute in Texas, there have been prosecutions for HIV exposure under general criminal laws.

Despite the fact that Texas does not have a criminal statute for HIV exposure or transmission,[705] HIV-positive persons have been prosecuted for HIV exposure under general criminal laws, including attempted murder and aggravated assault.[706]

Texas's aggravated assault statute makes it a felony in the second degree to cause serious bodily injury to another or use or exhibit a deadly weapon in the commission of the assault.[707] A felony of the second degree carries a punishment of two to twenty years in jail and a possible fine of $10,000.[708] If an aggravated assault is committed against a security officer, including a police officer, it is a felony in the first degree punishable by five to ninety-nine years in prison and a possible fine of $10,000.[709] Texas courts have held that HIV is a deadly weapon for the purposes of conviction under the aggravated assault statute[710] and numerous prosecutions in Texas have led to incarcerating individuals whose alleged criminal conduct presented no known risk of transmitting HIV.[711]

In *Mathonican v. State*, the Texas Court of Appeals found that HIV status can be considered a deadly weapon in aggravated assault and aggravated sexual assault cases. Similar to assault cases, sexual assault can be enhanced to aggravated sexual assault if the assailant used a deadly weapon in the

[705] Prior to 1994, Texas had an HIV transmission statute that made it a third degree felony punishable by up to ten years in prison and a $10,000 fine for an HIV-positive person to intentionally, and without consent, transfer bodily fluids to another. TEX. PENAL. CODE. Ann § 22.012 (1987). In 1994, Texas deleted this statute from its code but a handful of cases were charged under the statute prior to its repeal. In 1993 an HIV-positive man was charged of exposing a sexual partner to HIV. TJ Milling, *Woman Claims Lover Hid His HIV*, HOUSTON CHRONICLE, Aug. 17, 1993, at A 13. In 1992, an AIDS activist was charged with exposure to AIDS and HIV for scratching a police officer when he was being dragged from the Houston City Council Chambers. The charges were later dropped. *Id.* Another AIDS activist was charged after he bit a man on the hand and fingers. R.A. Dyer, *Ex-AIDS Activist Charged, Biting brings up rarely used law*, HOUSTON CHRONICLE, June 11, 1992, at A31.

[706] Parker v. State, 2010 WL 2784428 (Tex. App. 2010)(HIV positive defendant convicted and sentenced to life imprisonment for aggravated assault with a minor who tested positive for HIV); Weeks v. State, 834 S.W.2d 559 (Tex. App. 1992)(HIV-positive defendant was convicted of attempted murder for spitting at a prison guard and sentenced to life in prison); Najera v. State, 955 S.W.2d 698 (Tex. App. 1997)(HIV positive defendant convicted of aggravated sexual assault, aggravating element was that defendant's seminal fluid was considered a deadly weapon); Lopez v. State, 288 S.W.3d 148 (Tex. App. 2009) (remanding case in which defendant convicted of two counts of aggravated sexual assault, charged solely due to defendant's HIV status); Hoffman v. State, 2005 WL 1583552 (Tex. App. 2005)(affirming an eighteen-year sentence for defendant convicted of aggravated sexual assault of a child where the aggravating factor was that his seminal fluids were considered a deadly weapon); Sierra v. State, 2007 WL 2265170 (Tex. App. 2007)(HIV-positive defendant was convicted of three counts of aggravated sexual assault of a minor and sentenced to life imprisonment and to pay a fine of $10,000 per count); Suarez v. State, 2004 WL 1660938 (Tex. App. 2004).

[707] TEX. PENAL CODE ANN. § 22.02(a)(2009).

[708] § 12.33.

[709] § 22.02(2)(D); § 12.32(2009).

[710] Mathonican v. State, 194 S.W.3d 59 (Tex. App. 2006).

[711] Degrate v. State, No. 05-04-00218-CR , 2005 WL 165182 (Tex. Ct. App. Jan. 26, 2005); Emily Tsao, *Man Claiming HIV Accused of Biting Guard*, DALLAS MORNING NEWS, May 31, 2008, at 2B.

commission of the crime.[712] The HIV-positive defendant in this case was sentenced to ninety-seven years imprisonment for sexually assaulting another individual.[713] The original indictment held that the defendant's seminal fluid was a deadly weapon because he was HIV-positive.[714] The defendant appealed his case, asserting that the deadly weapon finding was erroneous because HIV status should not be considered a deadly weapon.

The court found that seminal fluid may be a deadly weapon "if the man producing it is HIV-positive and engages in unprotected sexual contact."[715] The court reasoned that a deadly weapon is anything that can be used to cause death or serious injury and that the seminal fluid from an HIV-positive man can cause such death or serious injury to another if that man engages in unprotected sex.[716] Even if the defendant did not ejaculate or otherwise expose the complainant to HIV, the court determined that the single fact that the defendant's seminal fluid "as used or as intended to be used" supported the deadly weapon finding.[717] This reasoning suggests that if an HIV-positive person engages in any unprotected sexual activity, regardless of the person's viral load and whether the sexual activity posed any possibility of transmission, criminal liability could follow.

Despite the scientific evidence on HIV transmission, numerous prosecutions still occur for activities that pose no risk of transmission to others. In 2006, an HIV-positive man, Campbell, was convicted of aggravated assault when he allegedly became confrontational and spat on a police officer's eyes and mouth during an arrest.[718] The officer did not test positive for HIV, but because Campbell's saliva was considered a possible means of transmitting HIV, his charges were elevated to aggravated assault with a deadly weapon, and he was later sentenced to thirty-five years in prison.[719]

In the 2009 appeal of the conviction, *Campbell v. State* presented the Texas Court of Appeals with an opportunity to revisit whether or not the saliva of an HIV-positive person could be considered a "deadly weapon." In 1992, the same court in *Weeks v. State* upheld the attempted murder conviction of an HIV-positive man for spitting on a prison guard, allegedly believing that his saliva could kill the guard.[720] In *Weeks* the defendant was sentenced to life in prison because he had two former felony convictions.[721] Unfortunately in both the *Weeks* and *Campbell* cases the state medical witness testified that there was a theoretical possibility of HIV transmission through saliva, and the convictions were upheld.[722]

These convictions were affirmed despite the fact that no officers involved in the altercations were infected with HIV and, most importantly, saliva has never been documented to transmit HIV. The

712 TEX. PENAL CODE ANn. § 22.021(a)(2)(A)(iv).
713 *See Mathonican*, 194 S.W.3d. at 6.
714 *Id.* at 67.
715 *Id.* at 69 citing Najera v. State, 955 S.W.2d 698, 701 (Tex. App. 1997)(court found that evidence of unprotected sex by an HIV-positive man, even if there was no evidence of ejaculation by defendant, is sufficient for a finding that penis and seminal fluids are deadly weapons).
716 *Id.*
717 *Id.* at 71.
718 Campbell v. State, No. 05-08-00736-CR, 2009 WL 2025344 (Tex. Ct. App. July 14, 2009).
719 *Id.*
720 Weeks v. State, 834 S.W.2d 559 (Tex. Ct. App. 1992).
721 *Id.*
722 *Campbell*, 2009 WL 2025344; *Weeks*, 832 S.W.2d 559.

CDC has concluded that there exists only a "remote" possibility that HIV could be transmitted through a bite and such transmission would have to involve various aggravating factors including "severe trauma, extensive tissue damage, and the presence of blood."[723] The CDC has also concluded that spitting alone has never been shown to transmit HIV.[724] The Texas Court of Appeals has set a poor precedent that HIV-positive individuals may be prosecuted for conduct that bears no risk or only a remote risk of HIV transmission and may be convicted for crimes solely on the basis of HIV status.

Other cases in Texas where HIV-positive persons have been prosecuted for conduct that pose no risk of HIV transmission include:

- An HIV-positive woman spit in the face of a prison guard and was convicted of attempted capital murder and sentenced to twenty-five years imprisonment.[725]
- A 26-year-old, HIV-positive man was charged with aggravated assault after he bit a security guard during a struggle in May 2008. Police suggested that the man used his HIV status "as a deadly weapon."[726]
- In 2005, an HIV-positive man's twenty-five year sentence for biting a police officer was upheld by the Texas Court of Appeals.[727] A nurse who testified at the trial said that HIV could be transmitted via the saliva in a bite and the court affirmed the conviction solely based on the nurse's testimony.

HIV-positive persons who fail to disclose their HIV status to their sexual partners may be prosecuted for aggravated assault.

Because an HIV-positive individual's saliva and other bodily fluids can be considered a deadly weapon in Texas, HIV-positive individuals may face aggravated assault charges for failing to disclose their HIV status to sexual partners.

In May 2009, an HIV-positive man was sentenced to five concurrent forty-five-year sentences for aggravated assault with a deadly weapon for exposing and infecting multiple women with HIV.[728] Because he allegedly did not disclose his HIV status to his partners and did not use condoms during sex, the prosecutors charged him with aggravated assault. The man had been involved in romantic, intimate relationships with each of the women and maintained that he himself may have even been

[723] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission, Can HIV be transmitted through a Human Bite?,* (March 25, 2010), http://www.cdc.gov/hiv/resources/qa/transmission.htm.
[724] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission, Can HIV be transmitted by being spit on by an HIV infected person?,* (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm.
[725] Brenda Rodriguez, *Sisterhood forms in Prison AIDS Center*, SAN ANTONIO EXPRESS NEWS, Sept. 15, 1997, at 8A.
[726] Emily Tsao, *Man Claiming HIV Accused of Biting Guard*, DALLAS MORNING NEWS, May 31, 2008, at 2B;
Ben Briscoe, *Saliva Again Considered Deadly Weapon in Oak Lawn Assault Case*, PEGASUSNEWS.COM (June 6, 2008), *available at* http://www.pegasusnews.com/news/2008/jun/06/saliva-again-considered-deadly-weapon-oak-lawn-ass/.
[727] Degrate v. State, No. 05-04-00218-CR, 2005 WL 165182 (Tex. Ct. App. Jan. 26, 2005).
[728] Diane Jennings, *Man Who Spread HIV Gets 45 Years*, DALLAS MORNING NEWS, May 30, 2009, at 1B.

infected by one of the complainants.[729] He will be eligible for parole after twenty-two-and-a-half years.[730]

In July 2010, an HIV-positive man pleaded guilty to aggravated sexual assault and other aggravated assault charges for failing to disclose his HIV status to his sexual partners.[731] The court found that the man's penis and seminal fluids were deadly weapons.

In October 2010, a 32-year-old HIV-positive Iraq war veteran was sentenced to three life sentences without parole for super aggravated assault of a child and continuous sexual abuse of a child.[732] A super aggravated assault conviction requires that the jury find that the defendant used a deadly weapon on a child, in this case HIV, during the assault.

In *Henry v. State*[733], the Texas Court of Appeals affirmed the seventy-five year sentence of an HIV-positive man for conviction for aggravated assault of a child, enhanced by two prior felony convictions. There was testimony at trial by a family nurse practitioner at the jail who had "extensive" HIV training. She testified that there was a "high risk of HIV transmission during unprotected sex" despite the fact that these broad generalizations are questionable and should not be applied to individual defendants without at least considering the viral load of a defendant and her/his medical treatment. Otherwise, "it is difficult to see how a qualified witness could reliably testify as to the risk posed by the defendant's sexual activity."[734]

HIV status as a consideration in sentencing even if there was no exposure to HIV.

HIV status can be considered admissible evidence at the punishment stage of a conviction if it is determined that HIV status is relevant to the offense. This consideration of HIV status most often involves cases of aggravated assault and aggravated sexual assault. Texas courts have found there is a "viable concern" that testimony and evidence of the defendant's HIV status should be admitted to consider the "potential long term effect of the injury" to the complainant.[735]

Though the courts have established that information concerning a defendant's life and characteristics may not be relevant to an issue of ultimate fact in the case, such considerations are appropriate when determining a sentence.[736] In *Martinez v. State*, the defendant was sentenced to life in prison and a $10,000 fine for aggravated sexual assault against a child. The defendant appealed

[729] Diane Jennings, *HIV-positive Frisco Man Blames Victims, Lawyers for Conviction*, DALLAS MORNING NEWS, May 28, 2009, *available at* http://www.dallasnews.com/sharedcontent/dws/dn/latestnews/stories/052909dnmetpadieu.41c13c6.html.
[730] *Id.*
[731] Jennifer Emily, *HIV Carrier who Endangered Women Pleads Guilty in Midst of Trial*, THE DALLAS MORNING NEWS, July 16, 2010, *available at* http://www.dallasnews.com/sharedcontent/dws/news/localnews/crime/stories/071510dnmetaidstrial.1418cf0c0.html.
[732] Craig Kapitan, *HIV Molester Handed Three Life Sentences*, EXPRESS NEWS, Oct. 7, 2010, *available at* http://www.mysanantonio.com/news/local_news/molester_with_hiv_gets_life_without_parole__times_three_104532769.html?c=y&page=1#storytop.
[733] No. 08-05-00364-CR, 2007 WL 2405798, at *1 (Tex. Ct. App. Aug. 23, 2007).
[734] AIDS AND THE LAW 7-26, David W. Webber ed., Aspen Publishers 4th ed. Supp. 2010 (1987).
[735] Suarez v. State, No. 14-03-00441-CR, 2004 WL 1660938, at *6 (Tex. Ct. App. July 27, 2004) (quoting Hunter v. State, 799 S.W.2d 356, 359 (Tex. Ct. App. 1990)) (citing Murphy v. State, 777 S.W.2d 44, 63 (Tex. Crim. App. 1988)).
[736] Sellers v. State, No. 05-94-00033-CR, 1996 WL 223537, at *1 (Tex. Ct. App. Apr. 29, 1996) (citing *Murphy*, 777 S.W.2d at 63).

his sentence, arguing that his sentence was largely based on his HIV status. The court, upholding the conviction and the sentence, found that HIV status can be considered as victim impact evidence at sentencing.[737] Victim impact evidence reflects the "defendant's personal responsibility and moral guilt and is thus relevant to punishment issues."[738]

Taking into account HIV status in the penalty phase has lead to increased sentences for many individuals in Texas, including those who did not expose others to HIV during the commission of the crime.

In *Atkins v. State,* an HIV-positive man was convicted of attempted sexual performance of a child and, because of two prior felony convictions, was sentenced to life in imprison.[739] The defendant in the case invited a minor to his hotel room where the defendant then sat on the bed, began undressing and fondling himself, and made suggestive overt comments referring to sex. The minor left the room and called for help before any physical or sexual contact took place. During the trial, the state presented evidence that the defendant was HIV-positive even though there was no contact that could remotely result in the transmission of HIV.

The defendant argued on appeal that his HIV-positive status had no probative value and should not have been considered for his sentencing. The court found that even though no sexual or physical contact occurred between the defendant and the minor, the defendant's HIV status could be considered as relevant evidence of the offense and used in assessing punishment because the defendant often had unprotected sex with men. This behavior, the court held, reflected the defendant's "willingness to expose others to the virus and his reckless disregard for the lives of others" and, as such, was pertinent to his sentencing.

In *Lewis v. State*, an HIV-positive man was sentenced to consecutive life sentences for aggravated sexual assault of a minor. The man inserted his finger into the child's vagina and masturbated while doing so. In his appeal of his sentence, he argued that his HIV status should not have been considered because at no time did he expose the child to HIV. The defendant also asserted that the state did not produce any medical testimony regarding the defendant's HIV status, the nature of HIV, or how the acts in question could have exposed the minor to a risk of transmission.[740] The court disagreed and found that the defendant's HIV-positive status was properly used during the trial and sentencing because the defendant had volunteered his HIV status to the police. The court held that "the jury may consider, as a circumstance of the offense, that the appellant's recognized HIV-positive status placed the victim of his sexual assault at risk of infection, whether or not the evidence shows any actual transmission of body fluids in a manner likely to infect."[741]

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[737] Martinez v. State, No. 05-03-01243-CR, 2004 WL 2378359, at *4 (Tex. Ct. App. Oct. 25, 2004).
[738] *Id.*
[739] Atkins v. State, No. 05-07-00586-CR, 2008 WL 2815087, at *1 (Tex. Ct. App. July 23, 2008).
[740] Lewis v. State, No. 07-08-00290-CR, 2010 WL 2400085, at *3 (Tex. Ct. App. June 16, 2010).
[741] *Id.* at *4.

Utah Statute(s) that Allow for Criminal Prosecution based on HIV Status:

UTAH CODE ANN. § 76-10-1309

Enhanced penalties: HIV-positive offenders

A person who is convicted of prostitution under Section 76-10-1302, patronizing a prostitute under Section 76-10-1303, or sexual solicitation under Section 76-10-1313 is guilty of a third degree felony if at the time of the offense the person is an HIV-positive individual, and the person:

(1) Has actual knowledge of the fact; or

(2) Has previously been convicted under Section 76-10-1302, 76-10-1303, or 76-10-1313.

UTAH CODE ANN. § 76-5-102.6

Propelling substance or object at a correctional or peace officer

(1) Any prisoner or person detained pursuant to Section 77-7-15 who throws or otherwise propels any substance or object at a peace or correctional officer is guilty of a class A misdemeanor, except as provided under Subsection (2).

(2) A violation of Subsection (1) is a third-degree felony if:

(a) The object or substance is:

(i) blood, urine, or fecal material; or

(ii) the prisoner's or detained person's saliva, and the prisoner or detained person knows he or she is infected with HIV, hepatitis B, or hepatitis C; and

(b) The object or substance comes into contact with any portion of the officer's face, including the eyes or mouth, or comes into contact with any open wound on the officer's body.

UTAH CODE ANN. § 76-3-203(3)

Sentences for felonies

In the case of a felony of the third degree, unless the statute provides otherwise, for a term not to exceed five years.

UTAH CODE ANN. § 76-3-301(1)(b)

Fines for persons

$5,000 for a felony conviction of the third degree.

HIV-positive persons convicted of sex offenses, particularly prostitution, may receive increased sentences.

Individuals with HIV in Utah should be aware that increased prison sentences may result from repeated violations of the state's prostitution laws. Utah is one of many states with a "sentence enhancement" statute that may increase penalties for HIV-positive offenders, regardless of whether they expose others to a significant risk of HIV infection. In Utah, if an individual pleads guilty or no contest to, or is convicted of any of the following offenses, she/he is required to take an HIV test:[742]

- Prostitution[743]
- Patronizing a prostitute[744]
- Sexual solicitation[745]

If the defendant tests positive and receives notice of the positive test result,[746] it will be a third-degree felony, punishable by up to five years in prison[747] and a $5,000 fine[748] if that HIV-positive defendant is subsequently convicted of one of the above noted offenses.[749] A violation of Utah's prostitution laws for those who are not HIV-positive is a Class B misdemeanor punishable by at most six months in prison[750] and a $1,000 fine[751] (or one year[752] and a $2,500[753] fine for repeat

[742] UTAH CODE ANN. § 76-10-1311 (West 2010).
[743] § 76-10-1302.
[744] § 76-10-1303.
[745] § 76-10-1313.
[746] *See* UTAH CODE ANN. § 76-10-1312 (West 2010) (outlining test result notification standards).
[747] § 76-3-203(3).
[748] § 76-3-301.
[749] § 76-10-1309.
[750] § 76-3-204.
[751] § 76-3-301.
[752] § 76-3-204.
[753] § 76-3-301.

prostitution[754] and "sexual solicitation" offenses[755].) HIV-positive persons, on the basis of their status alone, may face a prison sentence four years more than that of HIV-negative persons.

In September 2010, an HIV-positive sex worker was sentenced to five years imprisonment after pleading guilty to one count of third-degree felony solicitation.[756] The woman had tested positive for HIV in 2007 after her fourth prostitution conviction. She had also been imprisoned in 2008 and 2009 for prostitution.

This "penalty enhancement" law increases penalties for HIV-positive criminal defendants, regardless of whether they exposed others to a significant risk of HIV infection or if infection was even possible under the circumstances. Utah defines "prostitution" as engaging in "sexual activity" for a fee.[757] "Sexual activity" includes "acts of masturbation, sexual intercourse, or any sexual act involving the genitals of one person and the mouth or anus of another person, regardless of the sex of either participant."[758] Under this definition, which includes fingering and masturbation, felony-level prison sentences may result despite the fact that HIV cannot be transmitted in this manner.

The use of condoms or other protection is not a defense, even though they can significantly reduce risks of HIV transmission. Disclosure of HIV-positive status is not a defense on the face of the statute nor is a defendant's viral load taken into consideration, even though a low viral load (amount of active HIV virus in the human bloodstream) can significantly reduce transmission risks.

Sexual activity is not required for prosecution. Conviction of "loitering" in a public place for the purpose of being hired for prostitution also results enhanced penalties.[759] Because "patronizing" a prostitute is penalized, offering, agreeing, or entering a house of prostitution for the purpose of having sex for a fee is a third-degree felony even if no sexual act took place.[760] Offering or agreeing to commit any sexual activity for a fee also triggers sentence enhancement for repeat, HIV-positive offenders.[761] There is no consideration given to whether the act, if it had been completed, would have a risk of HIV exposure or transmission. The statute assumes that the completed act would pose a risk of HIV transmission.

HIV-positive sex workers in Utah should be aware that being an "inmate of a house of prostitution" also triggers enhanced sentencing.[762] Presumably, this means that any sex worker in a commercial sex establishment may face up to five years in prison,[763] regardless of whether they engaged in sexual activities posing significant risk of HIV infection.

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[754] § 76-10-1302(2).
[755] § 76-10-1313(2).
[756] Stephen Hunt, *HIV Positive Prostitute Sent to Prison*, SALT LAKE TRIBUNE, Sept. 17, 2010, http://www.sltrib.com/sltrib/home/50306321-76/hiv-positive-prison-patwardhan.html.csp.
[757] § 76-10-1302(1)(a).
[758] § 76-10-1301(4).
[759] § 76-10-1302(1)(c).
[760] § 76-10-1303.
[761] § 76-10-1313.
[762] § 76-10-1302(1)(b).
[763] § 76-10-1301(1).

HIV status may be taken into consideration during sentencing.

Transmission of HIV may be a factor in sentencing decisions. In *State v. Scott,* a man with chlamydia pleaded guilty to three counts of sodomy on a child for sexually abusing a six-year-old girl.[764] Each count came with the possibility of a ten-year-to-life sentence.[765] On appeal, the defendant argued that the trial court should not have considered his victim's infection with chlamydia as an "aggravating factor" when deciding whether to impose concurrent sentences (prison sentences served at the same time) or consecutive sentences (prison sentences served one after the other), because it was not certain that the defendant was the source of the victim's infection.[766] The Court of Appeals of Utah disagreed, as evidence suggested that the defendant had chlamydia, and the transmission of a sexually transmitted infection (STI) to a sexual abuse victim was a valid aggravating factor.[767] *Scott* suggests that the transmission of HIV may be taken into consideration for sentencing purposes and result in consecutive sentences for conviction of multiple charges of a sex offense.

There are currently proposals in Utah that would increase penalties for HIV-positive persons even if such persons were unaware of their HIV status.

As of the summer 2010, Utah's statutes related to HIV exposure were being considered for amendment that would broaden their terms.[768] A proposed senate bill would eliminate any requirement that an HIV-positive person have a previous conviction for a prostitution-related offense or knowledge of an HIV-positive test result.

Under this new law, if enacted, any person who committed a prostitution-related offense and knew or *should have known* that she/he was HIV-positive would receive a penalty enhancement. A court apparently could take into consideration highly private information concerning a defendant's sexual or health history to determine whether that defendant "should have known" that she/he was HIV-positive.

Assaulting a police or correctional officer with bodily fluids can result in increased prison sentences.

Utah has an HIV exposure statute specifically addressing situations where HIV-positive inmates throw or otherwise expose others to their bodily fluids during confrontations. Prison guards and other correctional employees involved in altercations with inmates often allege that they were attacked by HIV-positive inmates who intentionally spat at them or exposed them to their bodily fluids.

In Utah, it is a Class A misdemeanor, punishable by one year in prison[769] and a $2,500[770] fine, if any prisoner or any person[771] throws or otherwise propels any substance or object at a police or correctional officer.[772]

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[764] State v. Scott, 180 P.3d 774, 775 (Utah Ct. App. 2008).
[765] *Scott*, 180 P.3d at 776.
[766] *Id.* at 777.
[767] *Id.*
[768] *See* S.B. 155, 59th Leg., 2010 Gen. Sess. (Utah 2010).
[769] UTAH CODE ANN. § 76-3-204(1) (West 2010).

This offense becomes a third-degree felony, punishable by up to five years in prison[773] and a $5,000 fine,[774] if the object or substance is (1) blood, urine, or feces, or (2) the saliva of a person who knows she/he is infected with HIV, hepatitis B, or hepatitis C, and any of these substances come into contact with an officer's face, eyes, or mouth, or an open wound on the officer's body.[775] Neither the intent to transmit HIV nor actual transmission is required.

The CDC has concluded that there exists only a "remote" possibility that HIV could be transmitted through a bite and such transmission would have to involve various aggravating factors including "severe trauma, extensive tissue damage, and the presence of blood."[776] The CDC has also concluded that spitting alone has never been shown to transmit HIV.[777] Utah's statute ignores these scientific findings, leading to potential prosecutions for behavior that has at best a remote possibility of transmitting HIV.

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[770] § 76-3-301.
[771] Pursuant to UTAH CODE ANN. § 77-7-15 (West 2010).
[772] UTAH CODE ANN. § 76-5-102.6.
[773] § 76-3-203(3).
[774] § 76-3-301.
[775] § 76-5-102.6.
[776] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission, Can HIV be transmitted through a Human Bite?,* (March 25, 2010), http://www.cdc.gov/hiv/resources/qa/transmission.htm.
[777] CTR. FOR DISEASE CONTROL & PREVENTION, *HIV Transmission, Can HIV be transmitted by being spit on by an HIV infected person?,* (March 25, 2010) http://www.cdc.gov/hiv/resources/qa/transmission.htm.

Vermont Statute(s) that Allow for Criminal Prosecution based on HIV Status:

No specific statute on record.

There is no HIV-specific criminalization statute but there has been at least one case prosecuted under general criminal laws.

There are no statutes explicitly criminalizing HIV transmission or exposure in Vermont. However, at least one person has been prosecuted for HIV exposure under general criminal laws. In Vermont, a 31-year-old, HIV-positive man was charged with aggravated assault for spitting in the face of a police officer in July 2009.[778]

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[778] Brent Curtis, *AIDS Patient Faces Felony for Spitting at City Officer*, RUTLANDHERALD.COM, July 30, 2009, http://www.rutlandherald.com/apps/pbcs.dll/article?AID=/20090730/NEWS01/907300377/.

Virginia Statute(s) that Allow for Criminal Prosecution based on HIV Status:

VA. CODE ANN. § 18.2-67.4:1
Infected sexual battery; penalty.

A. Any person who, knowing he is infected with HIV, syphilis, or hepatitis B, has sexual intercourse, cunnilingus, fellatio, anallingus or anal intercourse with the intent to transmit the infection to another person is guilty of a Class 6 felony.
B. Any person who, knowing he is infected with HIV, syphilis, or hepatitis B, has sexual intercourse, cunnilingus, fellatio, anallingus or anal intercourse with another person without having previously disclosed the existence of his infection to the other person is guilty of a Class 1 misdemeanor.

VA. CODE ANN. § 32.1-289.2
Donation or sale of blood, body fluids, organs and tissues by persons infected with human immunodeficiency virus.

Any person who donates or sells, who attempts to donate or sell, or who consents to the donation or sale of blood, other body fluids, organs and tissues, knowing that the donor is, or was, infected with human immunodeficiency virus, and who has been instructed that such blood, body fluids, organs or tissues may transmit the infection, shall be guilty, upon conviction, of a Class 6 felony.

This section shall not be construed to prohibit the donation of infected blood, other body fluids, organs and tissues for use in medical or scientific research.

VA. CODE ANN. § 18.2-10(f)
Punishment for conviction of felony; penalty.

Class 6 felonies are punishable by either a term of imprisonment of one to five years, or in the discretion of the jury or the court trying the case without a jury, confinement in jail for up to one year and/or a fine of up to $2,500.

VA. CODE ANN. § 18.2-11
Punishment for conviction of misdemeanor
Class 1 misdemeanors are punishable by confinement in jail for up to one year and/or a fine of up to $2,500.

Virginia criminalizes a broad range of sexual activities for people living with HIV.

Virginia criminalizes oral sex, anal sex, and vaginal sex for people living with HIV. If an individual knows she/he has HIV and engages in these activities with the intent to transmit HIV, she/he is guilty of a felony that can result in up to five years of prison and a fine of up to $2,500. Even if the individual has no intent to transmit HIV, an individual who knows she/he has HIV is guilty of a misdemeanor if she/he engages in oral sex, anal sex, or vaginal sex without disclosing her/his HIV-status to her/his partner.

This statute may disproportionately punish an individual for being HIV-positive, regardless of whether the alleged conduct involved a risk of transmission. There is no exception for condom use and no consideration of the defendant's viral load, both of which might significantly reduce the risk of transmission. There is also no exception or consideration under the statute for situations in which both partners are HIV-positive.

An individual living with HIV must disclose her/his HIV status to a partner before engaging in certain sexual activities.

The misdemeanor statute requires the prosecution to demonstrate that the individual did not disclose her/his HIV status. Under the felony statute there is no requirement of disclosure but the prosecution must prove that the defendant intended to transmit HIV. The difference between the statutes rests in the defendant's state of mind which could be difficult to prove under the felony statute. Hypothetically, a person could disclose her/his HIV-positive status to her/his partner but still be prosecuted under the felony provision if there were elements to suggest that the person intended to transmit HIV.

Cases of arrests and prosecutions under Virginia's statute include:

- In October 2010, a man was charged with one count of felony infected sexual battery for allegedly exposing women to HIV without disclosing his status.[779]

- In 2008, a man was sentenced to nine months imprisonment after being convicted under Virginia's misdemeanor infected sexual battery statute.[780] The man had a sexual relationship with a woman and did not tell her his status until months into the relationship. After the disclosure, they continued their sexual relationship but she pressed charges against him after the relationship ended.

Virginia criminalizes the donation or sale of blood, bodily fluids, tissue, and organs of an HIV-positive person.

Involvement in the sale of blood, bodily fluids, tissue, and organs of a person with HIV is prohibited if the person knows the donor is or was HIV-positive and the materials may transmit

[779] *Man Accused of Infecting Women with HIV*, WTVR.COM, Oct. 15, 2010, *available at* http://www.wtvr.com/news/wtvr-man-infecting-women-with-hiv-101410,0,2366386.story.
[780] Keith Epps, *Keeping HIV Secret Lands Man in Jail*, FREDRICKSBURG.COM, March 27, 2008, http://fredericksburg.com/News/FLS/2008/032008/03272008/366616.

HIV.

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Washington Statute(s) that Allow for Criminal Prosecution based on HIV Status:

WASH. REV. CODE ANN. § 9A.36.011
Assault in the first degree

1. A person is guilty of assault in the first degree if he or she, with intent to inflict great bodily harm:
    a. Administers, exposes, or transmits to or causes to be taken by another, poison, the human immunodeficiency virus as defined in chapter 70.24 RCW, or any other destructive or noxious substance

Assault in the first degree is a Class A felony.

WASH. REV. CODE ANN. §§ 9.94A510, 9.94A.515, 9.94A.550
Class A felony

In Washington, a Class A felony carries a sentencing range of 93-318 months in prison and a fine of up to $50,000.

WASH. REV. CODE ANN. §§ 9.94A507
Sentencing of sex offenders

1. An offender who is not a persistent offender shall be sentenced under this section if the offender:
    a. Is convicted of:
        ii. Any of the following offenses with a finding of sexual motivation: Murder in the first degree, murder in the second degree, homicide by abuse, kidnapping in the first degree, kidnapping in the second degree, assault in the first degree, assault in the second degree, assault of a child in the first degree, assault of a child in the second degree, or burglary in the first degree

3. a. Upon a finding that the offender is subject to sentencing under this section, the court shall impose a sentence to a maximum term and a minimum term
    b. The maximum term shall consist of the statutory maximum sentence for the offense.

In Washington, any person may be imprisoned if she/he engages in activity with the "intent" to expose another to HIV.

Washington's HIV assault provision makes it a first-degree felony to expose another to HIV with the intent to inflict bodily harm. The statute fails to define what activity "administers" or "exposes" others to HIV. This may allow prosecutors to interpret the statute to include activities in which there is little to no risk of HIV transmission, such as spitting, biting, oral sex, sexual activity with the use of a condom, or performing or submitting to medical procedures. It also fails to account explicitly for an individual's viral load and as such an individual may be prosecuted under the statute even if her/his low viral load makes transmission extremely unlikely.

The Court of Appeals has rejected challenges to this statute on the basis that it violates the equal protection clauses of the United States and Washington constitutions, the privileges and immunities clause of the Washington constitution, and that it is unconstitutionally vague.[781] In *State v. Stark*, the Court of Appeals rejected an argument that the statute was unconstitutionally vague, and stated that "expose" refers to "conduct that can cause another person to become infected with the virus," an interpretation that provides no real guidance on defining such conduct.[782]

The Court of Appeals in both *Stark* and *State v. Whitfield* provide limited guidance that sexual activity with a condom may not constitute exposure under Washington's criminalization statute. In *Stark*, the Court specifically cites the fact that the defendant "engaged in unprotected sexual intercourse" in determining that his conduct constituted exposure. However, in *State v. Whitfield* the Court of Appeals interpreted exposure to include oral, anal, and vaginal sex without a condom.[783]

In Washington, disclosure of HIV status and using condoms or other protection may provide a defense that there was no intent to inflict harm through exposure or transmission of HIV. The Court of Appeals in both *Whitfield* and *Stark* inferred criminal intent because the defendants did not disclose their HIV status to their sexual partners and failed to use condoms.

For prosecution under this statute, the State must also show intent to inflict great bodily harm through exposure to HIV. Despite the fact that the statute requires intent to inflict great bodily harm, some courts have interpreted that knowing one's HIV-positive status and failing to take precautions limiting exposure is enough to constitute an intent to harm or expose another to HIV.[784] In *Stark*, the Court of Appeals determined that there was sufficient evidence of intent to harm because there was evidence that the defendant knew he had HIV and that it was *possible* to transmit HIV through oral and vaginal sex with women, and the defendant engaged in such conduct without

[781] State v. Whitfield, 134 P.3d 1203, 1211-13 (Wash. Ct. App. 2006); State v. Stark, 832 P.2d 109, 115 (Wash. Ct. App. 1992).
[782] *Stark*, 832 P.2d at 116 (affirming conviction and sentence of 163 months for HIV-positive man who engaged in unprotected oral and vaginal sex with three women). In *Stark*, the defendant was convicted under a second-degree assault statute, but the statutes were subsequently amended such that the language relating to HIV was removed from the second-degree assault statute and added to the first-degree assault statute.
[783] *Whitfield*, 134 P.3d at 1214 (Wash. Ct. App. 2006) (affirming conviction on 17 counts of first-degree assault and sentence of 178 years in prison for HIV-positive man who engaged in anal, oral, and vaginal sex with seventeen women, usually without a condom, with transmission occurring in five of the 17 cases).
[784] *See id.*; *Stark*, 832 P.2d at 111, 114 (Wash. Ct. App. 1992).

the use of a condom or other types of protection.[785] Similarly, in *Whitfield*, the Court of Appeals found sufficient evidence of intent based on the fact that the defendant knew he was HIV-positive; had been counseled on how HIV was transmitted, how to prevent transmission during sex, denied or failed to disclose that he had HIV or STIs to his sexual partners, and insisted on not using a condom or other type of protection.[786] In both cases defendants made statements indicating a desire to infect other individuals and that this evidence also lead to the court's determination of intent.[787] Similarly, in *State v. Ferguson*, a defendant convicted under this statute not only knew his status and knew he could transmit HIV to partners, but also made comments to acquaintances indicating that he did not care if his partners were infected and that he wanted to infect his partners.[788]

However, recently there has been a prosecutorial trend in Washington where if someone is HIV-positive and engages in sexual activities, that may be enough to arrest her/him for assault. The following cases had absolutely no evidence to suggest that the defendant intended to expose or transmit HIV to others but only engaged in sexual activities allegedly without disclosing her/his status:

- In October 2010, a 19-year-old perinatally-infected college student was charged with first-degree assault for having sex with his long-term girlfriend.[789]
- Also in October 2010, a 23-year-old, HIV-positive man was sentenced to 87 months imprisonment after pleading guilty to first-degree assault charges for allegedly not disclosing his status to a male sexual partner.[790]
- In June 2009, an HIV-positive man pleaded guilty to first-degree assault after he failed to disclose his HIV status to a male sexual partner[791]

Disclosure of one's HIV status may be a defense to prosecution.

Washington's statute does not explicitly provide an exception for disclosure or consent but, as noted above, there is supporting case law that disclosure may be considered as a possible defense against intent to transmit HIV though disclosure is not an absolute defense. In *State v. Ferguson*, the Washington Court of Appeals left open the question of whether consent could constitute a defense but held that, even if consent is a defense, the partner must have "knowledge of all relevant facts," including whether the defendant is using a condom.[792] In *Ferguson*, the defendant's partner knew the defendant was living with HIV before consenting to sex, but did not know that the defendant removed his condom during sex.[793] The court refused to determine whether consent could be a

[785] *See Whitfield*, 134 P.3d at 1213-14.
[786] *See Stark*, 832 P.2d at 114.
[787] *See Whitfield*, 134 P.3d at 1213; *Stark*, 832 P.2d at 114.
[788] *See* State v. Ferguson, 15 P.3d 1271, 1272-74 (Wash. 2001).
[789] *HIV-Infected Man Faces Assault Counts*, KHQQ6.com, Oct. 13, 2010.
[790] *HIV-Positive Man Sentenced for Assault*, THE SPOKESMAN REVIEW, Oct. 12, 2010, *available at* http://www.spokesman.com/stories/2010/oct/12/hiv-positive-man-sentenced-assault/.
[791] Meghan Cuniff, *HIV-Positive Man Faces New Charge*, SPOKESMAN REV. (Spokane, Wash.), July 14, 2009, at A5.
[792] State v. Ferguson, No. 21329-0-II, 1999 WL 1004992, at *6-*7 (Wash. Ct. App. Nov. 5, 1999). In *Ferguson,* the defendant was convicted under a second degree assault statute, but the statutes were subsequently amended such that the language relating to HIV was removed from the second degree assault statute and added to the first degree assault statute.
[793] *See id.*

defense to the statute, but held that, even if consent were a defense, the partner did not consent in these circumstances because she did not consent to sex without a condom.[794]

Upon conviction of multiple offenses, sentences for each offense can be imposed consecutively, resulting in lengthy incarceration.

In Washington, Class A felonies carry a maximum penalty of life in prison and a $50,000 fine. Prison sentences must run consecutively, meaning that sentences for every offense must be served one after the other. In *State v. Whitfield*, although the trial court interpreted multiple incidents of sexual activity with one partner as a single offense,[795] the activity with each of seventeen partners resulted in conviction of seventeen Class A felony counts and seventeen consecutive sentences, resulting in a 178-year sentence. The Court of Appeals rejected his argument that this amounted to cruel and unusual punishment.

HIV status may be a factor in sentencing.

In *In re Farmer*, the Washington Supreme Court imposed a sentence of almost eight years for a defendant in part due to his HIV-positive status upon his conviction of sexual exploitation of a minor and patronizing a juvenile prostitute.[796] [797] The court held that the defendant's knowledge or belief that he was HIV-positive and might transmit the virus to the two minors constituted deliberate, cruel, and malicious conduct that justified the 90-month sentence.[798]

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[794] *See id.*
[795] *See Whitfield.*, 134 P.3d at 1209.
[796] Farmer was one of the first people in the state to under-go a court ordered blood test to determine if he was HIV-positive. Such testing was later ruled unconstitutional by the Washington Supreme Court. Debra Carlton Harrell, *Steven Farmer, Central Figure in Case on HIV Testing, Dies*, SEATTLE POST INTELLIGENCER, Sept. 30, 1995, at B2.
[797] 835 P.2d 219, 220 (Wash. 1992) (per curiam).
[798] *See id.* Although the supreme court specified that the defendant knew or believed he had AIDS, previous opinions were amended to state that the court was relying on the fact that he knew or believed he "was HIV-positive." *See* State v. Farmer, 812 P.2d 858 (Wa. 1991).

West Virginia Statute(s) that Allow for Criminal Prosecution based on HIV Status:

W. VA. CODE ANN. §§ 16-4-20, 16-4-26
Communication of disease

It shall be unlawful for any person suffering from an infectious venereal disease to perform any act which exposes another person to infection with said disease, or knowingly to infect or expose another person to infection with said disease. ("Venereal disease" is not defined, but HIV is identified as "potentially sexually transmittable." *See* W. VA. CODE §§ 16-4-1, 64-7-17).

Violation of this statute is punishable by a fine of up to $100 and up to 30 days in jail.

West Virginia has a communicable disease statute that may criminalize HIV exposure.

West Virginia's Public Health Code imposes penalties of up to $100 and 30 days in jail for knowingly exposing others to venereal diseases. "Venereal disease" is not defined but HIV is considered "potentially sexually transmittable."[799] There have been no prosecutions under this statute and at the time of this publication the authors are not aware of a criminal prosecution of an individual on the basis of HIV status in West Virginia.

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[799] W. VA. CODE. ANN. § 64-7-17 (West 2010).

Wisconsin Statute(s) that Allow for Criminal Prosecution based on HIV Status:

WIS. STAT. § 973.017(4)
Aggravating factors; serious sex crimes committed while infected with certain diseases.

(b) When making a sentencing decision concerning a person convicted of a serious sex crime, the court shall consider as an aggravating factor the fact that the serious sex crime was committed under all of the following circumstances:

1. At the time that he or she committed the serious sex crime, the person convicted of committing the serious sex crime had a sexually transmitted disease or acquired immunodeficiency syndrome or had had a positive HIV test.
2. At the time that he or she committed the serious sex crime, the person convicted of committing the serious sex crime knew that he or she had a sexually transmitted disease or acquired immunodeficiency syndrome or that he or she had had a positive HIV test.
3. The victim of the serious sex crime was significantly exposed to HIV or to the sexually transmitted disease, whichever is applicable, by the acts constituting the serious sex crime.

HIV-positive status may lead to higher prison sentences for sex offenses.

Wisconsin has no statute explicitly criminalizing HIV transmission or exposure but Wisconsin allows HIV-positive status at the time of certain sex offenses to serve as an "aggravating factor" which may lead to additional prison time.

HIV status may be considered an aggravating factor in sentencing for the following offenses: first-degree or second-degree sexual assault;[800] first or second-degree sexual assault of a child;[801] repeated acts of sexual assault of the same child;[802] or sexual assault of a child placed in substitute care.[803]

In order for the individual's HIV-positive status to serve as an aggravating factor sentencing, the individual must have tested positive for HIV and known of his or her positive test result, and the crime must have "significantly exposed" the victim to HIV. The statute defines "significantly exposed" as "sustaining a contact that carries a potential for transmission of a sexually transmitted disease or HIV" through one or more of the following:[804]

[800] WIS. STAT. § 940.225(1),(2) (West 2010).
[801] § 948.02(1), (2).
[802] § 948.025.
[803] § 948.085.
[804] § 973.017(4)(a)(4).

- Transmission into a body orifice or onto mucous membrane; or exchange during the accidental or intentional infliction of a penetrating wound; or exchange, into an eye, an open wound, an oozing lesion, or other place where a significant breakdown in the epidermal barrier has occurred
- Of any of the following bodily fluids: blood; semen; vaginal secretions; cerebrospinal,[805] synovial,[806] pleural,[807] peritoneal,[808] pericardial,[809] or amniotic[810] fluid; or other body fluid that is visibly contaminated with blood.

Neither intent to transmit HIV nor actual transmission is required for HIV status to serve as an aggravating factor.

Aggravating factors may increase prison sentences by several years and even decades, depending on the specific offense and other factors considered in sentencing.[811]

Mere risk of contracting HIV may lead to an increased sentence, even if the defendant is HIV-negative.

At least one Wisconsin court has considered an HIV-negative defendant's risk of contracting and transmitting HIV in sentencing. In *State v. Holloway*, a trial court sentenced a woman convicted of prostitution to the maximum term, in part because of her "high HIV risk, both to herself and others," even though the woman was HIV-negative.[812]

Arrests and prosecutions for HIV exposure have also come under general criminal laws.

In 2008, an 18-year-old was charged with second-degree reckless endangerment, a felony punishable by up to 10 years imprisonment, for allegedly having unprotected sex with a fellow teenager and not disclosing his HIV status.[813] The defendant denied that he and the woman ever had sex.

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[805] Cerebrospinal fluid is a bodily fluid that surrounds the brain and spinal cord.
[806] Synovial fluid is bodily fluid that surrounds the joints.
[807] Pleural fluid is a bodily fluid that surrounds the lungs.
[808] Peritoneal fluid is a bodily fluid that surrounds organs in the abdominal cavity.
[809] Pericardial fluid is a bodily fluid that surrounds the heart.
[810] Amniotic fluid is a bodily fluid that surrounds a fetus in the womb.
[811] *See, e.g.*, WIS. SENTENCING COMM'N, SENTENCING WORKSHEET FOR FIRST DEGREE ASSAULT, *available at* http://wsc.wi.gov/docview.asp?docid=3298 (last visited June 29, 2010) (showing a mitigated level offense sentencing range of probation to 20 years in prison, an intermediate level offense sentencing range of five to 30 years, and an aggravated level offense sentencing range of 10 to 40 years).
[812] 551 N.W.2d 841, 843 (Wis. Ct. App. 1996).
[813] Crocker Stephenson, *Teen Charged with Not Disclosing HIV*, JOURNAL SENTINEL, April 23, 2008, http://www.jsonline.com/news/milwaukee/29583909.html.

Wyoming Statute(s) that Allow for Criminal Prosecution based on HIV Status:

No specific statute on record.

No explicit statute.
There are no statutes explicitly criminalizing HIV transmission or exposure in Wyoming. However, in some states, HIV-positive people have been prosecuted for HIV exposure under general criminal laws, such as reckless endangerment and aggravated assault. At the time of this publication, the authors were not aware of a criminal prosecution of an individual on the basis of that person's HIV status in Wyoming.

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UNITED STATES TERRITORIES

American Samoa Statute(s) that Allow for Criminal Prosecution based on HIV Status:

No specific statute on record.

No explicit statute:

There are no statutes explicitly criminalizing HIV transmission or exposure in American Samoa. However, in other jurisdictions HIV-positive people have been prosecuted for HIV exposure under general criminal laws, such as reckless endangerment and aggravated assault. At the time of this publication, the authors are not aware of a criminal prosecution of an individual on the basis of that person's HIV status in American Samoa.

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Guam Statute(s) that Allow for Criminal Prosecution based on HIV Status:

GUAM CODE ANN. tit. 9, § 28.10

First-degree felony: prostitution with knowledge of HIV status

A person convicted of prostitution who is determined to have known that he or she was infected with either HIV or AIDS at the time of the commission of the act shall be guilty of a felony of the first degree.

"Sexual penetration" includes an "intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body." GUAM CODE ANN. tit. 9, § 25.10(a)(9) (2009).

GUAM CODE ANN. tit. 9, § 80.30

Duration of imprisonment

In the case of a felony of the first degree, the court shall impose a sentence of not less than five (5) years and not more than twenty (20) years.

GUAM CODE ANN. tit. 9, § 80.50

Fines

A person who has been convicted of an offense may be sentenced to pay a fine or to make restitution not exceeding $10,000 when the conviction is of a felony of the first or second degree.

Engaging in prostitution while HIV-positive may result in imprisonment for up to twenty years.

Guam is one of many jurisdictions with a "penalty enhancement" provision specifically targeting HIV-positive individuals who engage in prostitution.[814] Such provisions frequently authorize increased prison sentences for HIV-positive individuals, regardless of whether they expose others to significant risks of HIV transmission.

In Guam, engaging in, offering to engage in, or agreeing to engage in any sexual conduct in return for a fee is normally a misdemeanor punishable by up to one year in prison[815] and a $1,000 fine.[816]

[814] *See generally* GUAM CODE ANN. tit. 9, § 28.10 (2009).
[815] GUAM CODE ANN. tit. 9, § 80.34(a) (2009).

However, if an individual convicted of prostitution is aware of her/his HIV-positive status, prostitution is a first-degree felony punishable by five to twenty years in prison[817] and a $10,000 fine.[818] Thus, HIV-positive individuals convicted of prostitution may receive prison sentences up to twenty times higher than those of HIV-negative individuals.

This prostitution law is intended to punish both HIV-positive sex workers and HIV-positive persons who seek out the services of a sex worker.[819]

Neither the intent to transmit HIV nor actual transmission is required. The use of condoms or other protection during sexual intercourse is not a defense and neither is the disclosure of HIV status to sexual partners. This statute thus fails to provide sex workers with HIV with any incentive to use condoms, because the increased sentence applies whether they do so or not.

Guam's prostitution law is a penalty enhancement statute that may severely increase the prison sentences of HIV-positive persons, regardless of whether they expose others to any risk of HIV transmission. Guam's definition of "sexual contact" includes sexual activities that do not present any risk of HIV transmission.[820] The territory's prostitution laws define "sexual contact" as including:

- The intentional touching of the victim's or actor's intimate parts;
- The intentional touching of the clothing covering the immediate area of the victim's or actor's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification."[821]

Under this definition, even contact between the hands of a sex worker and the clothes covering the penis of an HIV-positive man could result in penalty enhancement. Exchanging money for sexual penetration or any sexual conduct triggers elevated sentencing for any party who is HIV-positive regardless of whether the act, if completed, would have posed any risk of HIV exposure or transmission (i.e.: hand job).[822] Applying penalty enhancement provisions to this broad definition of prostitution may lead to felony-level penalties for HIV-positive persons engaging in sexual contact that cannot transmit HIV.

Note: Under Guam's public health laws, it is unlawful for any person with a "communicable disease" to "willfully expose himself" in any public place, street or highway.[823] Although Guam defines both HIV and AIDS as communicable diseases,[824] this exposure statute was intended to

[816] § 80.50(c); § 28.10(b)(1).
[817] § 80.30(a).
[818] § 80.50(a); § 28.10(b)(3).
[819] § 28.10(a) ("It is the intent of this section that guilt attach to both the payor and the recipient of the fee or pecuniary benefit that is the consideration for the act of prostitution, except that a police officer engaged in the performance of his or her official duties in the performance of an investigation of offenses committed under this chapter shall not be charged under this section.").
[820] § 28.10(c) (citing GUAM CODE ANN. tit. 9, § 25.10(a)(8) (2009)).
[821] § 28.10(c) (citing GUAM CODE ANN. tit. 9, § 25.10(a)(8) (2009)).
[822] *Id.*
[823] GUAM CODE ANN. tit. 10, § 3320 (2009).
[824] § 3301(a).

address contagious disease outbreaks, and is seemingly inapplicable to HIV exposure or transmission.

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Northern Mariana Statute(s) that Allow for Criminal Prosecution based on HIV Status:

No specific statute on record.

There are no criminal statutes explicitly addressing HIV or STD exposure in the Northern Mariana Islands.

There are no statutes explicitly criminalizing HIV transmission or exposure in the Northern Mariana Islands. Some states have prosecuted HIV-positive people for exposing others to the virus under general criminal laws, such as those governing reckless endangerment and aggravated assault. However, at the time of this publication the authors are not aware of this type of prosecution on the basis of an individual's HIV-positive status in the Northern Mariana Islands.

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Puerto Rico Statute(s) that Allow for Criminal Prosecution based on HIV Status:

No specific statute on record.

There are no criminal statutes explicitly addressing HIV or STI exposure in Puerto Rico.

There are no statutes explicitly criminalizing HIV transmission or exposure in Puerto Rico. While some states have prosecuted HIV-positive people for exposing others to the virus under general criminal laws, such as those governing reckless endangerment and aggravated assault, at the time of publication there were no reported cases of this type of prosecution in Puerto Rico.

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U.S. Virgin Islands Statute(s) that Allow for Criminal Prosecution based on HIV Status:

V.I. CODE ANN. tit. 14, § 888

Any person who exposes another to HIV by:

1. Engaging in unprotected sexual activity; or
2. Sharing hypodermic needles/syringes; or
3. Donating, selling, or attempting to donate or sell blood, semen, tissues, organs, or other bodily fluids for the use of another, except as determined necessary for medical research or testing;

When the infected person (1) knows at the time that he is infected with HIV, (2) has not disclosed his HIV-positive status, (3) and acts with the specific intent to infect the other person with HIV, shall be fined not more than $10,000 or imprisoned not more than ten years, or both.

Evidence that the person had knowledge of his HIV-positive status, without additional evidence, shall not be sufficient to prove specific intent.

Transmission of HIV is not required.

"Sexual activity" means:

- Insertive vaginal or anal intercourse on the part of an infected male;
- Receptive consensual vaginal intercourse on the part of an infected woman with a male partner; or
- Receptive consensual anal intercourse on the part of an infected man or woman with a male partner.

"Unprotected sexual activity" means sexual activity without the use of a condom.

Engaging in unprotected sexual intercourse with the specific intent to transmit HIV is prohibited.

In the U.S. Virgin Islands, conviction and imprisonment may result from engaging in unprotected sexual intercourse, but only under very specific circumstances. It is an offense punishable by up to ten years in prison and/or a $10,000 fine if an HIV-positive person (1) knows that she/he is HIV-positive, (2) has not disclosed HIV status to sexual partners, and (3) engages in unprotected sexual

activity with the specific intent to infect her/his partner with HIV.[825] Evidence that an HIV-positive person knew of her/his HIV status and engaged in unprotected sex is not sufficient, however, to prove specific intent to infect.[826] It is not clear what evidence would be required to prove intent to infect. Presumably, testimony regarding statements from an HIV-positive person that she/he wished to spread HIV could suffice.

Transmission of HIV to a sexual partner is not required for conviction.[827]

This HIV exposure law is explicitly limited to situations where HIV-positive persons expose others to activities known to transmit HIV, and where proof of intent to transmit HIV is required.

If a condom is used during sexual intercourse, then there is no violation of the statute.[828] In addition, the law's definition of "sexual activity" includes only: "Insertive vaginal or anal intercourse on the part of an infected male; receptive consensual vaginal intercourse on the part of an infected woman with a male; or receptive consensual anal intercourse on the part of an infected man or woman with a male."[829]

Under the terms of this HIV exposure law, it is a complete defense to prosecution if HIV status is disclosed to sexual partners before engaging in consensual sexual activity.[830] However, individuals living with HIV should be aware that disclosure of HIV status may be difficult to prove without witnesses or some form of incontrovertible evidence.

At the time of publication, the authors were not aware of any criminal prosecutions of individuals on the basis of their HIV-positive status in the U.S. Virgin Islands.

Sharing needles or syringes with the specific intent to infect another person with HIV is prohibited.

In the U.S. Virgin Islands it is an offense punishable by up to ten years in prison and/or a $10,000 fine if an HIV-positive person (1) knows that she/he is HIV-positive, (2) has not disclosed her/his HIV status, and (3) shares a hypodermic needle or syringe with the specific intent to infect another with HIV.[831]

Transmission of HIV is not required for prosecution.[832]

It is a complete defense to prosecution if HIV-status is disclosed to those sharing needles/syringes with an HIV-positive person.[833] However, individuals living with HIV should be aware that

[825] V.I. CODE ANN. tit. 14, § 888(a) (2010).
[826] 14, § 888(c).
[827] § 888(d).
[828] § 888(a) (limiting punishable conduct to "unprotected sexual activity"); § 888(e)(2) (defining "unprotected sexual activity" as sexual activity without the use of a condom).
[829] § 888(e)(1).
[830] § 888(a).
[831] § 888(a).
[832] § 888(d).
[833] § 888(a).

disclosure of HIV status may be difficult to prove without witnesses or documentation. Fortunately, successful prosecution hinges on the state's ability to prove specific intent to infect another with a needle.

This needle-sharing law is a rare example of a statute explicitly limited to the unusual situation where an HIV-positive person intentionally attempts to infect others. To be convicted of HIV exposure through sharing a needle, the government must prove that the HIV-positive defendant had the specific intent to infect by sharing the needle or syringe.[834] Evidence that an HIV-positive person knew of her/his HIV status and shared a contaminated needle is not **alone** sufficient to prove this specific intent requirement.[835]

Donating or selling blood, semen, human tissues, organs, or bodily fluids with the specific intent to infect another person is prohibited.

HIV exposure laws also prohibit HIV-positive persons from donating or selling blood, organs, and other human tissues or bodily fluids. Specifically, it is an offense punishable by up to ten years in prison and/or a $10,000 fine if an HIV-positive person (1) knows that she/he is HIV-positive, (2) has not disclosed her/his HIV status, and (3) donates, sells, or attempts to donate or sell blood, semen, tissues, organs, or bodily fluids for the use of another, except as necessary for medical research or testing. [836]

Transmission of HIV is not required for prosecution.[837]

It is a complete defense to prosecution if HIV-status is disclosed before donation of blood, tissues, and bodily fluids. [838]

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[834] § 888(c)(2010).
[835] § 888(c).
[836] § 888(b).
[837] § 888(d).
[838] § 888(a).

FEDERAL LAW
INCLUDING U.S. MILITARY LAW

Federal Criminal Statute(s)

18 U.S.C. § 1122

Donating or selling blood or other potentially infectious fluids or human tissues

After testing positive for HIV and receiving actual notice of that fact, HIV-positive individuals are prohibited from knowingly donating or selling, or knowingly attempting to donate or sell, blood, semen, tissues, organs, or other bodily fluids for use by another, except as determined necessary for medical research or testing.

Transmission of HIV is not required for conviction.

Penalties

Fine of not less than $10,000, imprisonment for not less than 1 year nor more than 10 years, or both.

Federal law explicitly addresses HIV transmission as a criminal offense in only one area, that of donation or sale of blood or other potentially infectious fluids or human tissues. Federal law provides that for conviction, the person must receive "actual notice" of testing HIV-positive,[839] although there is no requirement that the person be informed that HIV can be transmitted by blood, other body fluids, or human tissues. There is an exception for donations or sales that are necessary for medical research or testing.

Transmission of HIV is not required for conviction.

Because of widespread use of testing to screen HIV in donated blood (and widespread testing of donors of semen or other human body fluids or tissue), there is very little likelihood that a donor who knows of his/her HIV status will be undetected in attempting to donate or sell blood.

Although this law was originally enacted by Congress in 1994, there are no reported cases involving prosecutions under it. Many states have similar statutes, and prosecutions of individuals have been reported under those statutes.

Enhanced federal sentences for defendants with HIV

Unlike many states, Congress has not enacted a law imposing enhanced sentences for defendants in criminal cases involving conduct posing a risk of HIV transmission. The U.S. Sentencing

[839] 18 U.S.C. § 1122 (2006).

Commission considered issuing a guideline for enhanced sentences in cases of intentional exposure to HIV through sexual contact, and declined to do so given the rarity of such cases in the federal courts.[840] Instead, the Commission concluded that the federal guidelines' "general departure" provision,[841] which allows for an upward departure from the guideline range for aggravating circumstances, is the appropriate way to handle cases involving HIV. As a result of recent U.S. Supreme Court decisions,[842] the federal sentencing guidelines are now largely advisory, and federal judges can determine sentences based on concerns other than those set forth in the guidelines.

Very few federal cases have involved upward departure sentences involving sex offenses committed by HIV-positive defendants. For example, in *United States v. Blas*,[843] the Court of Appeals for the Eleventh Circuit affirmed an "extreme conduct" upward sentence departure based on an HIV-positive defendant's numerous sexual acts with a 15-year-old girl. The defendant had not disclosed his HIV infection, although the record indicated that the defendant used a condom at least some of the time. The court found that as a result of the sexual contact, the complainant feared that she was infected with HIV, suffered other psychological trauma, and repeatedly sought HIV testing. In another federal case, *United States v. Burnett*,[844] the court's use of the defendant's HIV status to impose an upward departure was much more problematic. In that case, there was no risk of HIV transmission presented by the underlying offense, public lewdness when soliciting an undercover federal officer for sex, and the court's opinion fails to determine the risk of HIV transmission involved in the sexual activity that was solicited from the undercover agent.

In at least one case, a federal judge has imposed a sentence far beyond the federal sentencing guidelines based solely on HIV status. In 2009, a federal judge in Maine determined a pregnant woman's sentence based solely off of her HIV status.[845] The woman was charged with possession and use of false immigration documents, a crime for which the federal sentencing guidelines recommend 0-6 months incarceration. The woman had been incarcerated for almost 4 months at the time of her sentencing, and both the defense and prosecution recommended that the judge enter a sentence of "time served." However, the judge sentenced her to a total of 7.9 months because, he argued, the interests of the "unborn child" necessitated that the woman remain in prison past her due date so that he could ensure she received treatment to prevent HIV transmission to the child she was carrying.

Prosecution of HIV-Positive Federal Inmates for Risk of HIV Transmission to Correctional Officers

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[840] U.S. SENTENCING COMM'N, REPORT TO CONGRESS: ADEQUACY OF PENALTIES FOR THE INTENTIONAL EXPOSURE OF OTHERS THROUGH SEXUAL ACTIVITY TO THE HUMAN IMMUNODEFICIENCY VIRUS 4 (1995) (concluding that HIV transmission issues are rare in federal sentences, based on a review of 235 criminal cases sentenced in fiscal year 1993 in which HIV was mentioned in only four cases, and in only one of those cases, which was not a sexual offense case, was intentional transmission of HIV an issue).

[841] U.S. SENTENCING COMMISSION, FEDERAL SENTENCING GUIDELINES MANUAL § 5K2.0 (2009).

[842] *See, e.g.,* United States v. Booker, 543 U.S. 220 (2005); Blakely v. Washington, 542 U. S. 296 (2004); Apprendi v. New Jersey, 530 U.S. 466 (2000).

[843] 360 F.3d 1268 (11th Cir. 2004).

[844] 545 F. Supp. 2d 1207 (N.D. Ala. 2008).

[845] *See* Brief for National Advocates for Pregnant Women, Center for HIV Law and Policy, Verrill Dana, LLP on behalf of Medical, Public Health and HIV Experts and Advocates as Amici Curiae Supporting Respondents, United States v. "Mrs. T", (No. 09-19-B-W) available at http://www.hivlawandpolicy.org/resources/view/412.

Although there are many convictions of HIV-positive persons, increased penalties for posing an alleged risk of HIV transmission, and matters in state courts for altercations (often involving biting or spitting) with law enforcement personnel, very few such federal cases have been reported. The reported cases tend to involve substantial prison sentences for conduct posing a limited risk of HIV transmission. One such case, *United States v. Moore*,[846] involved an assault prosecution of a federal inmate for severely biting two federal corrections officers. The Court of Appeals for the Eighth Circuit concluded that HIV is not transmitted by exposure to saliva, and thus it rejected the argument that the risk of HIV transmission from a human bite is such that an HIV-positive inmate's teeth and mouth can be used as a deadly and dangerous weapon under the federal assault statute.[847] But in another inmate biting case, *United States v. Sturgis*,[848] the Court of Appeals for the Fourth Circuit concluded to the contrary on the question of whether saliva could transmit HIV, given the expert testimony in the record before it, and thus concluded that the inmate's HIV infection was a basis for finding that the inmate's teeth were used as a deadly weapon. The conclusion in *Sturgis* that HIV is transmitted by saliva exposure from a human bite was followed in *United States v. Studnicka*,[849] which resulted in a ten year prison term for an HIV-positive federal inmate's biting of a correctional officer.

Prosecution of HIV-Related Offenses in the U.S. Military

Members of the U.S. Armed Forces have been prosecuted and convicted for offenses involving sexual transmission or risk of transmission of HIV. Although applicants with HIV are barred from enlisting in the armed forces, military service members are tested for HIV, and those who test positive are retained in the service as long as they are able to meet fitness for duty standards. All prosecutions of service members for HIV-related offenses are pursuant to the Uniform Code of Military Justice, which does not include any provision explicitly addressing HIV transmission. Instead, service members with HIV have been prosecuted under general criminal assault provisions, similar to the criminal assault prosecutions of civilians with HIV under state law. Military service members have also been prosecuted under two provisions unique to the military: failing to follow safe-sex orders and for conduct prejudicial to good order. All military cases appear to involve sexual contact, and thus there is an absence of reported biting, spitting, or similar assault cases of the sort prosecuted in the civilian state courts.

Military service members with HIV been convicted of aggravated assault in cases in which HIV status is disclosed and their sexual partner consents, or in cases in which condoms are used.

Numerous military service members with HIV have been prosecuted under the aggravated assault provision contained in Article 28 of the Uniform Code of Military Justice (UCMJ).[850] Article 128

[846] 846 F.2d 1163 (8th Cir. 1988). Although the court rejected the argument that the inmate's HIV infection caused his mouth and teeth to be a deadly and dangerous weapon, the court instead held that because of the risk of disease transmission and infection, other than HIV, the deadly and dangerous weapon standard nevertheless applied, and the inmate received a five year sentence to run consecutively with his current sentence.
[847] 18 U.S.C. §§ 111, 1114 (2006).
[848] 48 F.3d 784 (4th Cir. 1995) (affirming sentence of fourteen years based on the underlying offense, as well as a finding that the inmate committed perjury at trial concerning his knowledge of when he tested HIV-positive).
[849] 450 F. Supp. 2d 680 (E.D. Tex. 2006).
[850] 10 U.S.C. § 928.

defines an aggravated assault as an assault undertaken with a means likely to produce death or grievous bodily harm. Assault in this context has been defined as any contact, even that consented to by the service member's partner. Article 128 includes both attempted, as well as completed, assaults and thus an HIV-positive service member's attempt to have unprotected, consensual anal intercourse, which was abandoned before achieving penetration, has been held to be an aggravated assault.[851] Military courts have held that there is no requirement that the defendant have a specific intent to infect a sexual partner, but instead only a general intent to engage in unprotected sex.[852] Because a partner in an assault cannot, as a matter of law, consent to the assault, disclosure of HIV status is not a defense. Thus, even in cases in which a service member has disclosed his HIV status to his sexual partner, and the partner has given an informed consent to the sexual contact, the service member has been convicted of aggravated assault.[853]

The military courts have stretched the meaning of the "likely to produce" death or grievous bodily harm element in the aggravated assault definition to encompass circumstances that present nothing more than a highly remote possibility of harm. First, in *United States v. Johnson*,[854] the Army Court of Military Review decided that "likely" need only be "more than merely a fanciful, speculative, or remote possibility," and it therefore held that unprotected anal intercourse "would have been likely to transmit a disease which can ultimately result in death." Next, in *United States v. Joseph*,[855] the Court of Military Appeals further diluted the meaning of "likely." In that case, the service member had sexual intercourse with a woman on one occasion without having disclosed his HIV infection. At trial, it was undisputed that the service member used a condom, although his partner testified that the condom broke during sex. A medical expert testified that the risk of HIV transmission as a result of one act of sexual intercourse was small, and that using a condom, although not 100 percent effective in preventing HIV transmission, would be extremely effective in reducing the risk. Although this evidence clearly indicated that transmission of HIV was not likely from the one act of sexual intercourse, the court reframed the issue, concluding that "the question is not the statistical probability of HIV invading the victim's body, but rather the likelihood of the virus causing death or serious bodily harm if it invades the victim's body."[856] The court thus abandoned any requirement that the risk of HIV transmission must be likely, with the result that under *Joseph*, conviction under the Article 28 aggravated assault provision is possible for sexual contact posing any theoretical risk

[851] United States v. Johnson, 30 M.J. 53, 56 (C.M.A.) (affirming conviction and sentence of confinement for six years, total forfeitures, reduction in rank, and dishonorable discharge), *cert. denied*, 498 U.S. 919 (1990).
[852] United States v. Schoolfield, 40 M.J. 132 (C.M.A. 1994) (holding that HIV-positive service member who had unprotected sex with a woman on five occasions without disclosure of his HIV status, but without evidence that he intended to infect her with HIV, was guilty of aggravated assault), *cert. denied*, 513 U.S. 1178 (1995).
[853] United States v. Bygrave, 46 M.J. 491 (C.A.A.F. 1997) (affirming conviction on ground that informed consent to sexual intercourse with HIV-positive service member was not a defense).
[854] United States v. Johnson, 27 M.J. 798, 801 (A.C.M.R. 1988), *aff'd*, 30 M.J. 53 (C.M.A.), *cert. denied*, 498 U.S. 919 (1990). In *Johnson*, there was no act of sexual intercourse because the case was prosecuted as an attempted assault. The court's ruling requiring "more than remote" likelihood of HIV transmission thus was a determination regarding the likelihood of transmission resulting from one instance of unprotected anal intercourse.
[855] 37 M.J. 392 (C.M.A. 1993).
[856] 37 M.J. 392, 397. The court's ruling may reflect the fact that Joseph's sexual partner subsequently tested positive for HIV. For a similar ruling, see *United States v. Stewart*, 29 M.J. 92 (C.M.A. 1989) (holding that unprotected sexual intercourse with a woman on numerous occasions, apparently resulting in the woman's infection with HIV, was aggravated assault in view of the probability that death would result from HIV infection).

of transmission, including sexual contact using condoms or other protection.[857] Along this same line, in *United States v. Goldsmith*,[858] the Air Force Court of Criminal Appeals held that unprotected sex, even if the probability of transmission was only 1 in 1,000 in each instance of sexual intercourse, is an aggravated assault. Consistent with a zero risk approach, in *United States v. Perez*,[859] the court held that evidence of risk of transmission was insufficient to support conviction for aggravated assault because there was no evidence that the defendant, who had had a vasectomy, could transmit HIV.

At the same time, however, the Court of Appeals for the Armed Forces has started to show receptiveness to evidence that a low viral load reduces the risk of HIV transmission below the level necessary to prove an aggravated assault. In *United States v. Dacus*,[860] the court applied *Joseph* and affirmed, based on the defendant's guilty plea, aggravated assault convictions for sexual intercourse involving inconsistent condom use. At sentencing, however, undisputed expert testimony established that the defendant's viral load was extremely low, and although he posed a risk of HIV transmission from sexual intercourse, such transmission was "very, very unlikely." A concurring opinion noted that had the defendant chosen to litigate the issue, then the evidence would not satisfy the statutory aggravated assault standard. The court used that same reasoning in *United States v. Upham*[861] when it reversed an aggravated assault conviction based on evidence that the risk of HIV transmission was too remote because of the defendant's low viral load. Even if the use of aggravated assault charges in military cases is limited by these decisions in the future, military prosecutors can bring charges under the UCMJ for violation of safe-sex orders, as discussed below.

Military service members with HIV have been convicted of disobeying a "safe-sex order" in cases in which HIV status is not disclosed or in which condoms are not used.

HIV-positive military service members, upon testing positive, are counseled regarding the risk of HIV transmission, and are routinely issued orders from their commanding officers that they both disclose their HIV infection to their sexual partners, avoid sexual activities posing a significant risk of HIV transmission, and use condoms or other protection to reduce the risk of transmission. Violations of safe-sex orders are prosecuted under Article 90 of the UCMJ,[862] which provides for court-martial of service members who willfully disobey a lawful order. Obtaining the consent of a sexual partner, after disclosure of HIV status, to sexual intercourse without a condom or other protection would be irrelevant to whether a safe-sex order was violated. Military service members with HIV have been convicted under Article 90 for using condoms but failing to disclose HIV status,[863] and for both failing to use condoms or other protection and for failing to disclose.[864]

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[857] The implication in *United States v. Joseph*, 37 M.J. 392 (C.M.A. 1993), that any risk of HIV transmission whatsoever is adequate to support an aggravated assault charge conflicts with the military's own HIV prevention approach, which uses "safe-sex" orders to compel service members to reduce, but not entirely eliminate, the risk of transmission. Apparently no service member has been prosecuted for an aggravated assault based on behavior (i.e. disclosure of HIV status, use of condoms) that conforms to a safe-sex order.

[858] No. ACM 31172, 1995 WL 730266 (A.F. Ct. Crim. App. Nov. 20, 1995).

[859] 33 M.J. 1050 (A.C.M.R. 1991).

[860] 66 M.J. 235 (C.A.A.F. 2008).

[861] 66 M.J. 83 (C.A.A.F. 2008), *aff'g* 64 M.J. 547 (C.G. Ct. Crim. App. 2006). The court did, however, affirm a conviction for a lesser offense, assault consummated by a battery.

[862] 10 U.S.C. § 890(2)(2006).

[863] United States v. Negron, 28 M.J. 775, 776–79 (A.C.M.R.) (upholding conviction for violation of safe-sex order by service member who used condom during heterosexual intercourse but did not inform partner of his HIV infection), *aff'd*, 29 M.J. 324 (C.M.A. 1989).

Service members have been convicted of violating safe-sex orders for their sexual relations with their spouses.[865] Article 90 failure to obey a lawful order charges can be combined with the aggravated assault charge discussed above.[866]

In September 2010, an airman in Kansas was charged with aggravated assault, adultery, indecent acts for having sexual relations in public, obstruction of justice, and violating a squadron commander's orders for allegedly engaging in unprotected and undisclosed sex with various partners.[867] The squadron commander's order included that the airman not engage in any sex without disclosing his HIV status and to always use condoms. If convicted on all charges the airman could face at least fifty-three years imprisonment, a dishonorable discharge, forfeiture of pay, and a reduction of rank.

Some safe-sex orders have been overly broad in prohibiting service members from engaging in behaviors that pose no risk of HIV transmission, but have nevertheless been upheld as lawful orders in subsequent prosecutions. In *United States v. Womack*,[868] the service member was issued an order requiring him to take affirmative steps "during any sexual activity to protect your sexual partner from coming in contact with your blood, semen, urine, feces, or saliva."[869] The defendant service member was accused of having oral-genital contact with another man, and thus the order was upheld on the basis that the service member's saliva came in contact with his partner during sexual activity. At trial, two military doctors testified that "it was possible but not very likely that one could transmit the virus through his saliva incident to an act of fellatio."[870] The military judges acknowledged, however, that as more is learned about HIV, future safe-sex orders would have to be adjusted "to reflect current knowledge."

Military service members with HIV have been convicted of "conduct prejudicial to good order" for engaging in sexual activities posing a risk of HIV transmission.

Military service members with HIV have been convicted under the "general article," Article 134 of the UCMJ.[871] This catch-all provision criminalizes all conduct "to the prejudice of the good order and discipline in the armed forces" and "all conduct of a nature to bring discredit upon the armed forces." Despite the absence of any reference in this provision to behaviors posing a risk of HIV transmission, or any reference to what behaviors involve a sufficient risk to constitute a violation, the Court of Military Appeals upheld its application to HIV-positive service members on the basis that the safe-sex counseling they have received provides sufficient notice regarding conduct

[864] United States v. Dumford, 30 M.J. 137 (C.M.A.) (unprotected consensual heterosexual sex without informing partner of HIV infection), *cert. denied*, 498 U.S. 854 (1990); United States v. Barrows, 48 M.J. 784, 785 (Army Ct. Crim. App. 1998) (same); United States v. Sargeant, 29 M.J. 812, 814–17 (A.C.M.R. 1989) (same).
[865] United States v. Pritchard, 45 M.J. 126 (C.A.A.F. 1996), *cert. denied,* 520 U.S. 1253 (1997). Prosecutions involving spousal sexual contact, or others involving regulation of service members' consensual sexual contact, particularly with civilians, could violate constitutional privacy rights, *see* Lawrence v. Texas, 539 U.S. 558 (2003), although no military case has directly addressed this issue.
[866] United States v. Sorey, NMCCA 9901186, 2004 CCA LEXIS 2, 2004 WL 49093 (N-M. Ct. Crim. App. Jan. 8, 2004).
[867] *Kansas Airman with HIV charged with assault for sex*, ASSOCIATED PRESS, Sept. 24, 2010 *available at* http://technews.tmcnet.com/topics/associated-press/articles/104087-kan-airman-with-hiv-charged-with-assault-sex.htm.
[868] 29 M.J. 88 (C.M.A. 1989).
[869] 29 M.J. 88, 89. The order also required disclosure of HIV status to all health care professionals.
[870] 29 M.J. 88, 89.
[871] 10 U.S.C. § 934 (2006).

prohibited by Article 134.[872] As is the case with aggravated assault charges under the UCMJ, disclosure of HIV status and consent of the service member's sexual partner is not a defense to an Article 134 prosecution.[873]

[872] United States v. Woods, 28 M.J. 318, 319 (C.M.A. 1989).
[873] United States v. Morris, 30 M.J. 1221 (A.C.M.R. 1990) (affirming Article 134 conviction, and sentence of bad-conduct discharge, forfeiture of $400 pay per month for three months, and restriction to the limits of his base, for service member who disclosed HIV status and used condoms approximately 25 percent of the time with female sex partner).

Illustrations and Resources of Prosecutions and Arrests based on HIV status in the United States

The following section provides illustrations of prosecutions and arrests in the United States, in addition to a fact sheet on the issues surrounding HIV criminalization.

The first two charts represent the number of cited arrests, prosecutions, and sentencing enhancements based on HIV status in various jurisdictions. The first chart is arranged by alphabetical order based on the name of the jurisdiction. The second chart is arranged according to aggregate number of prosecutions. These charts provide a snapshot of all the cases illustrated in this volume. As noted earlier, although the authors have attempted to include all reported cases from either news media sources or official judicial opinions, not all cases of HIV exposure are reported in the media and many prosecutions do not result in published judicial opinions. As a result, the cases represented here are assumed not to constitute an exhaustive representation of all HIV-related prosecutions in the U.S. but are likely only a sampling of a much more widespread, but generally undocumented, use of criminal laws against people with HIV.

The third chart in the series is an illustrative list of arrests and prosecutions in the United States for HIV exposure between 2008 – November 16, 2010.

The last resource is a fact sheet that provides a summary on the issues surrounding HIV criminalization in the United States. This fact sheet is intended to be used by advocates as informative talking points on HIV criminalization.

Arrests and Prosecutions for HIV Exposure in the United States: 50 States, U.S. Territories, and Military Courts

List is illustrative not exhaustive (Last Updated November 16, 2010)

Chart 1 *arranged according to alphabetical order*

Jurisdiction	Number of Prosecutions and Arrests✧	Sentence Enhancements Due to HIV-Positive Status	HIV-Specific Criminal Statute?*
Alabama	1	0	No* *
Alaska	0	1	Yes (Sentence Enhancement)
Arizona	0	0	No
Arkansas	5	0	Yes
California	10	1	Yes
Colorado	6	0	Yes
Connecticut	0	0	No
Delaware	0	0	Yes
District of Columbia	0	0	No
Federal Law, including U.S. Military	25	2	Yes
Florida	10	3	Yes
Georgia	7	0	Yes
Hawaii	0	0	No
Idaho	4	0	Yes
Illinois	18	0	Yes
Indiana	15	4	Yes
Iowa	36	0	Yes
Kansas	1	0	Yes
Kentucky	3	0	Yes
Louisiana	8	1	Yes
Maine	0	0	No
Maryland	7	0	Yes
Massachusetts	4	1	No+
Michigan	14	1	Yes
Minnesota	3 (and 2 civil commitments	1	Yes

	proceedings)		
Mississippi	2	0	Yes
Missouri	13	1 (status was a determining factor in civil commitment)	Yes
Montana	0	0	No**
Nebraska	0	0	No
Nevada	2	0	Yes
New Hampshire	1	0	No
New Jersey	4	0	Yes
New Mexico	1	0	No
New York	4	1 (civil commitment hearing currently in progress and is based on the defendant's HIV status)	No **
North Carolina	4	0	Yes
North Dakota	0	0	Yes
Ohio	25	0	Yes
Oklahoma	6	0	Yes
Oregon	3	1	No
Pennsylvania	12	0	Yes
Rhode Island	0	0	No**
South Carolina	5	0	Yes
South Dakota	5	0	Yes
Tennessee	50 (39 for aggravated prostitution)	1	Yes
Texas	22	4	No
Utah	0	1	Yes (Sentence Enhancement)
Vermont	1	0	No
Virginia	2	0	Yes
Washington	8	1	Yes
West Virginia	0	0	No**
Wisconsin	0	1	Yes (Sentence Enhancement)
Wyoming	0	0	No
American Samoa	0	0	No
Guam	0	0	Yes
Northern Mariana Islands	0	0	No
Puerto Rico	0	0	No
U.S. Virgin Islands	0	0	Yes
Totals:	350	26	36

Chart 2 *arranged according to number of prosecutions and arrests*

Jurisdiction	Number of Prosecutions and Arrests✧	Sentence Enhancements Due to HIV-Positive Status	HIV-Specific Criminal Statute?*
Tennessee	50 (39 for aggravated prostitution)	1	Yes
Iowa	36	0	Yes
Ohio	25	0	Yes
Federal Law, including U.S. Military	25	2	Yes
Texas	22	4	No
Illinois	18	0	Yes
Indiana	15	4	Yes
Michigan	14	1	Yes
Missouri	13	1 (status was a determining factor in civil commitment)	Yes
Pennsylvania	12	0	Yes
California	10	1	Yes
Florida	10	3	Yes
Louisiana	8	1	Yes
Washington	8	1	Yes
Maryland	7	0	Yes
Georgia	7	0	Yes
Colorado	6	0	Yes
Oklahoma	6	0	Yes
Arkansas	5	0	Yes
Minnesota	3 (and 2 civil commitments proceedings)	1	Yes
South Carolina	5	0	Yes
South Dakota	5	0	Yes
Idaho	4	0	Yes
Massachusetts	4	1	No[+]
New Jersey	4	0	Yes
New York	4	1 (civil commitment hearing currently in progress and is based on the defendant's HIV status)	No **
North Carolina	4	0	Yes
Kentucky	3	0	Yes
Oregon	3	1	No
Mississippi	2	0	Yes
Nevada	2	0	Yes
Virginia	2	0	Yes
Alabama	1	0	No* *

Kansas	1	0	Yes
New Hampshire	1	0	No
New Mexico	1	0	No
Vermont	1	0	No
Alaska	0	1	Yes (Sentence Enhancement)
Arizona	0	0	No
Connecticut	0	0	No
Delaware	0	0	Yes
District of Columbia	0	0	No
Hawaii	0	0	No
Maine	0	0	No
Montana	0	0	No**
Nebraska	0	0	No
North Dakota	0	0	Yes
Rhode Island	0	0	No**
Utah	0	1	Yes (Sentence Enhancement)
West Virginia	0	0	No**
Wisconsin	0	1	Yes (Sentence Enhancement)
Wyoming	0	0	No
American Samoa	0	0	No
Guam	0	0	Yes
Northern Mariana Islands	0	0	No
Puerto Rico	0	0	No
U.S. Virgin Islands	0	0	Yes
Totals:	350	26	36

KEY

✧ Please note, there is some overlap between prosecution and sentence enhancement cases (i.e.: the defendant may be the same in both proceedings). Also, some of the prosecutions are reflective of prosecutions that occurred prior to changes in the state's criminal law related to HIV exposure (i.e.: California and Texas)

*Many prosecutions also arise under general criminal laws (i.e.: reckless endangerment, aggravated assault, etc.) even if the state has an HIV-specific statute.

**These states have "communicable" or "contagious disease" control statutes that criminalize STI exposure, which may or may not include HIV. Many of these statutes were enacted prior to the discovery of HIV and have typically not been enforced. The penalties under the statutes are limited to misdemeanors. There is no record of a case of HIV exposure ever being prosecuted under such statutes.

†Massachusetts statute, Mass. Gen. Laws Ann. 265 § 22b(f)(2008), mandates a fifteen year to life sentence for a defendant who has forced sexual intercourse with a child under 16 years old, the defendant "knew or should have known" that she/he was a carrier for an STI or STD, and that the minor could have contracted the STD or STI. This statute has not yet been applied to HIV-positive persons.

Arrests and Prosecutions for HIV Exposure in the United States, 2008–2011

(List is illustrative, not exhaustive)

DATE	STATE	TYPE OF EXPOSURE	LAW	DESCRIPTION & OUTCOME
December 2011	VA	Sex	Infected Sexual Battery	A 52-year-old man pleaded guilty to having carnal knowledge of a minor, a felony, and to a misdemeanor count of having sex with a person without disclosing he was infected with the human immunodeficiency virus. The second charge was reduced from a felony to a misdemeanor because there was no evidence that he intended to infect her, but still carries a sentence of up to 12 months in jail. http://www2.timesdispatch.com/news/2011/dec/13/tdmet02-man-with-hiv-convicted-of-having-sex-with--ar-1539505/
November 2011	IL	Biting	Criminal Transmission of HIV	A 36-year-old man is being charged with transmission of HIV, after Oak Park police said he bit a police officer's thumb and broke the skin. http://triblocal.com/oak-park-river-forest/2011/11/23/man-accused-of-biting-cop-charged-with-transmitting-hiv/
November 2011	NC	Sex	Violation of state public health laws	A 27 year-old man was arrested and charged in Raleigh with violation of state public health laws for not disclosing his HIV status before sex. http://abclocal.go.com/wtvd/video?id=8419703&syndicate=syndicate&section
October 2011	ID	Sex	Transferring body fluids containing HIV	A 50-year-old man was arrested on charges of transferring body fluids containing HIV for having sex with women without disclosing his status. If convicted he faces 15 years in prison and/or a $5000 fine.
October 2011	IL and MO	Sex	Criminal transmission of HIV (IL) and knowingly transmitting HIV (MO)	A man was charged with one count of criminal transmission of HIV in Illinois, and three counts of knowingly transmitting HIV in Missouri, for allegedly failing to tell his female sexual partners that he was HIV positive. It is unclear whether there was any transmission involved. http://www.ksdk.com/news/article/281200/3/Police-Man-knowingly-passed-HIV-onto-others
September 2011	OH	Spitting	Felonious Assault	A woman was charged with felonious assault for allegedly spitting on people and telling them that she had HIV. Saliva cannot transmit HIV but Ohio courts have held that if blood is mixed with saliva then an HIV positive person can be convicted of felonious assault. [*HIV-positive woman behind bars after spitting on several bar patron*, Sept. 2, 2011, http://www.woio.com/story/15383123/hiv-positive-woman-spits-on]
August 2011	MD	Sex	Aggravated Assault	A man was charged with assault for allegedly failing to tell his girlfriend that he was HIV positive prior to them having sex. [Adam Bednar, *Man Charged with Assault for Not Disclosing HIV Status*

				Before Sex, North Baltimore Batch, Aug. 24, 2011, http://northbaltimore.patch.com/articles/crime-man-charged-with-assault-for-not-disclosing-hiv-status-before-sex]
August 2011	TN	Sex	Criminal Exposure to HIV	A 39-year-old man was charged with criminal exposure to HIV for failing to tell his live-in girlfriend that he was HIV positive. [*Man Charged with Exposing Girlfriend to HIV*, wreg.com, Aug. 17, 2011, http://www.wreg.com/news/wreg-man-charged-with-exposing-girlfiriend-to-hiv-20110817,0,7741295.story]
August 2011	FL	Sex	Unlawful Acts Relating to HIV Exposure	A man was indicted on 20 counts of criminal exposure to HIV for allegedly failing to tell his female sexual partner that he was HIV positive. [Man charged with exposing woman to HIV, Jackson Sun, Aug. 11, 2011, http://www.jacksonsun.com/article/20110811/NEWS01/108110319]
August 2011	FL	Sex	Unlawful Acts Relating to HIV Exposure	A man was arrested for allegedly failing to inform his male sexual partner of his HIV status. Charges were later dropped because, for the purposes of Florida's HIV exposure statute, sexual intercourse under state law is defined as being between a man and a woman. The 2nd Circuit Court of Appeals held in a July 2011 decision that the narrow definition of "sexual intercourse" precludes using the statute in cases of same-sex consensual relationships. [*Charges dropped against HIV positive man accused of endangering others*, cfnews13.com, August 19, 2011, http://www.cfnews13.com/article/news/2011/august/297505/Charges-dropped-against-HIVpositive-man-accused-of-endangering-others]; *Man Charged With not telling Partner he was HIV Positive*, Tampa Bay Online, Aug. 5, 2011, http://www2.tbo.com/news/breaking-news/2011/aug/05/man-charged-with-not-telling-partner-he-was-hiv-po-ar-248600/]
August 2011	GA	Sex	Reckless Conduct	A man was arrested for allegedly failing to tell his girlfriend of his HIV positive status. The complainant has tested positive for HIV. [Alaya Boykin, *Douglas County Man Charged with Infecting Girlfriend with HIV*, The Atlanta Journal-Constitution, Aug. 4, 2011, http://www.ajc.com/news/douglas-county-man-charged-1075552.html#.Tjr-ZLQeal4.email]
July 2011	NY	Spitting	Reckless Endangerment	A write of habeas corpus was denied in the case of a man of was convicted of reckless endangerment after spitting at police officers saying that he had AIDS. Spit cannot transmit HIV. The ruling mainly focused on Carmona's argument that it was a violation of his due process rights to have his medical records entered into evidence at trial. The court held that Carmona did not provide evidence that admission of his medical records violated his constitutional rights. [Carmona v. Connolly, 2011 WL 1748694 (S.D.N.Y. July 12, 2011)]
July 2011	TN	Sex	Criminal Exposure to HIV	A man was arrested for allegedly failing to tell his wife, who has since tested positive for HIV, that he was HIV positive. [Beth Burger, *More HIV Victims Speak Out*, TimesFreePress.com, July 30, 2011, http://timesfreepress.com/news/2011/jul/30/more-hiv-victims-speak-out/]
July 2011	TN	Sex	Criminal Exposure to HIV	An arrest was made in the case of a man who allegedly failed to tell his sexual partner, whom he met online, that he was HIV positive. [*Man Surrenders to CPD After Allegations of Criminal*

				Exposure to HIV, Eagle94.com, July 25, 2011, http://www.eagle943.com/pages/10418760.php?contentType=4&contentId=8598475; *Clarksville Woman in HIV Exposure Case Warns Others*, The Leaf Chronicle, June 22, 2011, http://www.theleafchronicle.com/article/20110623/NEWS01/106230315/Clarksville-woman-HIV-exposure-case-warns-others?odyssey=tab|topnews|text|FRONTPAGE]
June 2011	OH	Biting	Felonious Assault	An HIV positive woman has been charged with felonious assault for allegedly biting a police officer. *[HIV Positive Woman Accused of Biting Police Officer*, WLWT.Com, June 24, 2011, http://www.wlwt.com/r/28344700/detail.html]
June 2011	OH	Sex	Felonious Assault	A 32-year-old man was charged with felonious assault for allegedly not disclosing his HIV status to a young man he met on n dating service. The young man has since tested positive for HIV. [Kelli Wynn, *Boy, 15, infected by man with HIV*, Dayton Daily News, June 15, 2011, http://www.daytondailynews.com/news/crime/boy-15boy-15-infected-by-man-with-hiv-1185800.html]
May 2011	FL	Biting	Criminal Transmission of HIV	A 30-year-old man was charged with criminal transmission, among other charges, for allegedly trying to bite a police officer while resisting arrest for shoplifting. The charges were dropped when it was discovered that the man did not in fact have HIV. [Marcos Restrepo, *Public Defender: Broward detainee charged with criminal transmission of HIV does not have the virus*, Florida Independent, June 10, 2011, http://floridaindependent.com/33508/public-defender-broward-detainee-charged-with-criminal-transmission-of-hiv-does-not-have-the-virus; Marcos Restrepo, *More Details Emerge about South Florida criminal HIV transmission case,* Florida Independent, June 3, 2011, http://floridaindependent.com/32611/hiv-criminal-transmission-broward]
May 2011	OH	Sex	Felony Prostitution	A 32-year-old HIV positive sex worker was charged with felony prostitution. Most prostitution charges are misdemeanors but being HIV positive increases the penalties to felony level offenses. Prior to this incident, she was arrested and sentenced to one year in prison for felony prostitution in January 2010. [Doug Page, *Convicted HIV-positive prostitute arrested again*, Dayton Daily News, May 19, 2011, http://www.daytondailynews.com/news/crime/convicted-hiv-positive-prostitute-arrested-again--1164324.html]
April 2011	OK	Biting	Assault and Battery	An HIV positive man bit a police officer during an arrest and was charged with felony assault and battery, in addition to other charges. [Jordan Gummer*, HIV-Positive Inmate Accused of Biting Jailer*, Times Record Online, April 29, 2011, http://www.swtimes.com/news/article_976c2328-7266-11e0-9ec0-001cc4c03286.html]
April 2011	OH	Sex	Felonious Assault	After being indicted in April, a 29-year-old former wrestler was convicted Nov. 23, 2011 of 14 felonious assault counts for allegedly not telling his sexual partners that he was HIV positive. [*HIV positive wrestler indicted*, Cincinnati.com, April 25, 2011, http://news.cincinnati.com/article/20110425/NEWS010702/104260303/, http://www.suntimes.com/news/nation/9035383-418/ex-pro-wrestler-andre-davis-convicted-in-hiv-case.html]

April 2011	NY	Sex	First Degree Reckless Endangerment	A 20-year-old man was arrested for felony reckless endangerment for allegedly failing to tell his girlfriend that he was HIV positive. The man pleaded guilty to five counts of misdemeanor reckless endangerment and was sentenced to one year imprisonment. [*Buffalo Man admits exposing five to HIV; faces 1 year imprisonment,* Buffalo News, July 9, 2011, http://www.buffalonews.com/city/article482521.ece*; Man charged for not telling of HIV infection*, Wall Street Journal, April 21, 2011, http://online.wsj.com/article/APc4540a75baea4c3da2586727a82d0c86.html]
April 2011	IL	Sex	Criminal Transmission of HIV	A man was charged with criminal transmission of HIV for not telling his sexual partner about his HIV condition. The man was arrested after police searched his car and found his medications for HIV and asked the man if he was HIV positive and had disclosed such information to his sexual partner, who was also in the car. [*Man convicted on AIDS case arrested on sex charge*, The Herald News, April 21, 2011, http://heraldnews.suntimes.com/news/4941274-418/man-convicted-on-aids-case-arrested-on-sex-charge.html]
April 2011	IA	Sex	Criminal Transmission of HIV	A 44-year-old HIV positive man turned himself into police on a warrant charging criminal transmission of HIV. He is accused of engaging in "intimate contact with another person" while being HIV positive. [*Police Reports*, thonline.com, April 19, 2011, http://www.thonline.com/article.cfm?id=318509]
April 2011	WI	Sex	HIV as an aggravated factor in serious sex acts	A 35-year-old HIV positive man was charged with sexual assault of a child. Wisconsin does not have an HIV specific criminal law but in making sentencing decisions, a judge may consider a person's HIV status as an aggravating factor. [*Man with HIV Charged with Sexual Assault of a Child*, WAUSAUDAILYHERALD.com, April 19, 2010, http://wsau.com/news/articles/2011/apr/19/charges-filed-against-hiv-spreader/]
April 2011	GA	Sex	Reckless Conduct	An HIV positive man was charged with reckless conduct, among other charges, for allegedly having sex with one of his students. [*Band teacher with HIV allegedly had sex with 15-year-old student*, CBSnews.com, April 14, 2011, http://www.cbsnews.com/8301-504083_162-20053944-504083.html]
March 2011	IN	Sex	Failure to Warn	A 20-year-old perinatally infected HIV-positive woman was arrested for allegedly failing to disclose her status to her sexual partner. [*Woman Accused of Not Telling Partner About HIV*, TheIndyChannel.com, March 30, 2011, http://www.theindychannel.com/news/27362307/detail.html]
March 2011	PA	Spitting, Biting	Terroristic Threats	An HIV positive man pleaded guilty to two counts of assault and one count of making terroristic threats for spitting and biting at police officers. He said that that he hoped the officers would get HIV. There is a very low chance of HIV being transmitted by blood spatter because HIV cannot live outside of the body for very long and HIV cannot be transmitted via saliva or biting. The man was eventually sentenced to six months to a year in jail and will have three months of probation. [*Eaton Police AIDS Assault: Man who said he had AIDS gets prison for assault on police*, The Morning Call, May 13, 2011, http://articles.mcall.com/2011-05-13/news/mc-easton-police-aids-assault-20110513_1_easton-man-

				codes-officer-count-of-terroristic-threats; Todd Heywood, *HIV-positive PA man pleads guilty of terroristic threats*, Michigan Messenger, March 29, 2011, http://michiganmessenger.com/47741/hiv-positive-pa-man-pleads-guilty-of-terroristic-threats]
March 2011	ID	Sex	Transfer of Bodily Fluids Which May Contain HIV	A man was sentenced to 15 years imprisonment for not disclosing his HIV status and having unprotected sex with multiple partners. It is not known if any of the partners tested positive for HIV. The man pleaded guilty in Dec. 2010 and will be eligible for parole after two years. [*Boise man with HIV sentenced for unprotected sex*, KIVITV.com, March 25, 2011, http://www.kivitv.com/Global/story.asp?S=14323844; *Boise man charged with transferring HIV*
March 2011	IN	Sex	Failure to Warn	A man was sentenced to two years imprisonment for HIV non-disclosure after not telling his female sexual partner he had HIV. [*Man sentenced in HIV –related case*, Journal and Courier, March 26, 2011, http://www.jconline.com/article/20110326/NEWS03/103260327/Man-sentenced-HIV-related-case?odyssey=mod|newswell|text|FRONTPAGE|s]
March 2011	OH	Sex	Felonious Assault	A HIV+ man was charged with three counts of felonious assault for allegedly not disclosing his HIV status to his sexual partners. [Sarah Webber, *Vermillion man charged for spreading HIV*, Sandusky Register, March 17, 2011, http://www.sanduskyregister.com/news/2011/mar/17/aidschargessw031711xml]
March 2011	FL	Sex	Unlawful Acts Related to HIV Exposure	An HIV+ man was charge with unlawful acts related to HIV exposure, among other charges, for allegedly raping a 13-year -old boy. [*Police: Man with HIV raped boy, 13*, wesh.com, March 14, 2011, http://www.wesh.com/r/27185799/detail.html]
March 2011	IN	Sex	Failure to warn persons at risk	A 33-year-old HIV positive man was charged with six counts failing to warn, along with other charges, for allegedly molesting a boy. [*Police: Man with HIV Molests 8-year-old boy*, indychannel.com, March 11, 2011, http://www.theindychannel.com/news/27168892/detail.html]
March 2011	MO	Bite	Reckless Exposure to HIV	An HIV positive man was charged with reckless exposure to HIV, assault on an officer, and resisting arrest for allegedly biting a police officer. [*Man with HIV charged with biting O'Fallon police officer, kmov.com*, kmov.com, March 10, 2011 http://www.kmov.com/news/local/Man-with-HIV-charged-with-biting-OFallon-Missouri-police-officer-117739179.html]
March 2011	IN	Sex	Failure to Warn	A man pleaded guilty to failing to warn his sexual partner that he was HIV positive. Failure to warn is a class D felony in Indiana, punishable by six months to three years imprisonment. [Sophia Voravong, *Suspect admits to sex without disclosing that he had a STD*, jconline.com, March 5, 2011, http://www.jconline.com/article/20110305/NEWS03/103050328/Suspect-admits-to-sex-without-disclosing-he-had-STD]
March 2011	TN	Sex	Criminal Exposure to HIV	A 28-year-old HIV-positive man was arrested for allegedly having sex without disclosing his status. [*Man charged with exposing 14 year old boy to HIV*, wmctv.com, March 2, 2011, http://www.wmctv.com/Global/story.asp?S=14176472]

March 2011	MO	Sex	Reckless Exposure to HIV	A 36-year-old man was charged with reckless exposure to HIV for allegedly engaging in sex with his girlfriend without disclosing his HIV status. [Kristin Gosling, *Man charged with criminal transmission of HIV*, ksdk.com, March 3, 2011, http://www.ksdk.com/news/article/247286/3/Man-charged-with-criminal-transmission-of-HIV]
March 2011	MO	Sex	Reckless Exposure to HIV	In response to a domestic violence call, police arrested a man for criminal transmission of HIV after discovering that the man allegedly never told his girlfriend about his condition. He was charged with eight counts of reckless exposure to HIV. [Area Crime Reports, Webster-Kirkwood Times, March, 4, 2011, http://www.websterkirkwoodtimes.com/Articles-i-2011-03-04-173882.114137-Area-Crime-Reports.html#ixzz1Fe6WSUtC]
Feb. 2011	CO	Sex	Prostitution with the knowledge of being HIV positive	A woman was arrested for the felony charge, prostitution with the knowledge of being HIV positive, in addition to two misdemeanors for allegedly soliciting an undercover cop. If convicted of the HIV-specific charge she could up to face three years imprisonment. [*Denver Woman Accused of Knowingly Spreading HIV*, Fox News, Feb. 2, 2011, http://www.foxnews.com/us/2011/02/02/denver-prositute-arrested-knowingly-spreading-hiv-virus/]
Jan. 2011	SC	Sex	First-degree harassment and Exposing others to HIV	A 30-year-old man was arrested for allegedly exposing others to HIV. [*Man Exposed Others to HIV, Police Say*, Augusta Chronicle, January 21, 2011, http://chronicle.augusta.com/news/crime-courts/2011-01-21/man-exposed-others-hiv-police-say]
Jan. 2011	KS *but Military Prosecution*	Sex	Aggravated assault plus violating a squadron commander's orders, adultery, indecent acts for having sexual relations in front of others, and obstruction of justice.	A US airman was sentenced to eight years imprisonment and will be dishonorably discharged after serving his time for having unprotected sex with multiple sexual partners without disclosing his HIV status. The man was found guilty on seven of eight counts of aggravated assault and violating squadron commander's orders to notify sexual partners about his HIV status and to use condoms. He was also convicted of indecent acts for having sex in front of others and adultery. None of the man's sexual partners tested positive for HIV. Upon his dishonorable discharge the man will lose his medical benefits. [*Kan. Airman with HIV charged with assault for sex*, Associated Press, Sept. 24, 2010, available at http://technews.tmcnet.com/topics/associated-press/articles/104087-kan-airman-with-hiv-charged-with-assault-sex.htm; *Airman gets 8 years imprisonment in HIV exposure case*, AP, January 20, 2011.].
Jan. 2011	TN	Sex	Criminal Exposure of Another to HIV	A man was arrested for allegedly not telling his sexual partner that he was HIV positive. If convicted, the man could face up to three to fifteen years imprisonment. [*Man charged with criminal exposure to HIV*, Jacksonsun.com, January 20, 2011, http://www.jacksonsun.com/article/20110120/NEWS01/110119038/-1/newsfront2/Man+charged+with+criminal+exposure+to+HIV]
Jan. 2011	MO	Sex	Reckless Exposure to HIV	A man pleaded guilty to recklessly exposing his former girlfriend to HIV and was sentenced to ten years imprisonment. Probation was denied. The former girlfriend alleges that she did not know the defendant was HIV positive until they had broken up. She has since tested positive for HIV. [*SW Missouri man pleads guilty to infecting woman with HIV*, January 18, 2011, http://www.stltoday.com/news/local/crime-and-

				courts/article_ebe29ba2-2307-11e0-988e-0017a4a78c22.html
Jan. 2011	MO	Sex	Reckless Exposure to HIV	A man was charged with six counts of reckless exposure to HIV for failing to tell his sexual partner about his HIV status. He was convicted of four of the counts and sentenced to 30 years imprisonment. The partner has since tested positive. [Patrick M. O'Connell, *Northwoods man charged in HIV case*, stltoday.com, http://www.stltoday.com/news/local/crime-and-courts/article_939b9889-f8fb-5cfd-9004-430cca57ebfd.html, January 14, 2011; *Northwoods man sentenced in HIV case*, stltoday.com, , January 14, 2011, http://www.stltoday.com/news/local/crime-and-courts/article_f8017690-1fe4-11e0-936e-0017a4a78c22.html]
Dec. 2010	TN	Sex	Criminal Exposure to HIV	A man was arrested for criminal exposure to HIV and aggravated statutory rape for allegedly having sex with a 16-year-old boy. Charges were dropped in February due to a lack of probably cause. [*Man Accused of Statutory Rape, Exposing 16-year-old boy to HIV in Memphis*, abc24.com, Dec. 21, 2010, http://www.abc24.com/news/local/story/Man-Accused-of-Statutory-Rape-Exposing-16-Year/iJJUEIQX_0O4Igc7dUOW4Q.cspx]
Dec. 2010	CO	Spitting	Aggravated Assault	A man, who claimed he was HIV positive, spit on an officer's cheek and was to be charged with second degree assault. It was later determined that the man was HIV negative. Though HIV cannot be transmitted via saliva, the Boulder police department told reporters that spitting is an "extremely serious" matter for police and all officers after being spit on receive a medical check at a hospital. [Heath Urie, *Boulder Police: Man said he was HIV positive before spitting on officer*, Daily Camera, , Dec. 21, 2010, http://www.dailycamera.com/ci_16904190?source=most_viewed]
Dec. 2010	VA	Sex	Infected Sexual Battery	A HIV-positive man pleaded guilty to carnal knowledge of a child and pleaded no contest to infected sexual battery for engaging in sex with an underage girl. The girl has since tested positive for HIV. In January 2011, he was sentenced to 50 years imprisonment. [Carrie J. Sidener, *Amherst man found guilty in teen sex case*, New Era Progress, Dec. 17, 2010, http://www2.neweraprogress.com/news/amherst-news/2010/dec/17/amherst-man-found-guilty-teen-sex-case-ar-723677/; Scott Marshall, *Man sentenced to 50 years for sex with Teen*, neweraprogress.com, January 12, 2011, http://www2.neweraprogress.com/news/amherst-news/2011/jan/12/man-hiv-sentenced-50-years-child-sex-charges-ar-770448]
Nov. 2010	GA	Bite	Assault by an HIV infected person on an officer	A 26-year-old HIV positive man was charged with assault by an HIV infected person on an officer for allegedly biting the officer when he refused to get his fingerprints taken. The police officer's skin was not broken. [*HIV Positive man bites police officer*, WRCBtv.com, Nov. 20, 2010, http://www.wrcbtv.com/Global/story.asp?S=13542076]
Nov. 2010	MI	Sex	Sexual Penetration of an Uninformed Partner	A man from Grand Rapids was charged with two felony counts of sexual penetration of an uninformed partner, punishable by up to four year imprison for each count, for allegedly having sex with two women without disclosing his HIV status. He was eventually

				sentenced to time already served – 181 days. [*GR Man sentenced for HIV sex charge*, wood8tv, May 10, 2011, available at http://www.woodtv.com/dpp/news/local/grand_rapids/GR-man-sentenced-for-HIV-sex-charge*; Instead of Jail Time, it is marriage for a man accused of not informing his partner he has AIDS*, mlive.com, May 11, 2011, available at http://www.mlive.com/news/grand-rapids/index.ssf/2011/05/instead_of_jail_time_it_is_mar.html; Lisa LaPlante, *HIV Positive Man charged with having sex, not telling partners of status, wsbt.com*, Nov, 15, 2010, http://www.wsbt.com/news/fox17-hivpositive-man-charged-with-h-111510,0,7741407.story; Nate Reens, *Grand Rapids Man jailed for allegedly failing to tell his sex partners he is HIV positive*, The Grand Rapids Press, Nov. 15, 2010, http://www.mlive.com/news/grand-rapids/index.ssf/2010/11/grand_rapids_man_jailed_for_al.html]
Nov. 2010	GA	Sex	Reckless Conduct, HIV Infected Persons	An HIV positive man was sentenced to life imprisonment plus ten years for rape and reckless conduct for allegedly raping a woman. Under the reckless conduct charge it is a felony for HIV positive persons to have sexual intercourse without first disclosing their HIV status. [Andria Simmons, *HIV positive man to stand trial on rape charge*, Atlanta Journal Constitution, Nov. 12, 2010, http://www.ajc.com/news/gwinnett/hiv-positive-man-to-738690.html; *HIV Positive Man Gets Life Sentence for Rape*, Examiner.com, http://www.examiner.com/crime-in-atlanta/hiv-positive-man-get-s-life-sentence-for-rape]
Nov. 2010	NV	Sex	Intentional Transmission of HIV	Two HIV-positive men were charged with intentional transmission of HIV after meeting another man through a male dating website. One of the defendant's, who has an undetectable viral load, dating profile noted that he was HIV positive and he and his co-defendant maintain that the complainant knew of their HIV positive status. Though the Nevada statute is called "intentional transmission of HIV", neither the intent to transmit nor actual transmission of HIV is required for prosecution. Conviction under the statute carries a maximum ten years imprisonment. [Interview with defendant and his attorney, names have been omitted to protect the identities of the parties (November 11, 2010)].
Nov. 2010	TN	Spitting	Aggravated assault and Criminal Exposure of Another to HIV	A man allegedly spit at a detention officer's face while he was in custody and was charged with aggravated assault and criminal exposure of another to HIV. The family of the man said that the guard used pepper spray to subdue the man, prompting the spitting and, moreover, that the man is not even HIV positive and as of July 2009 had not tested positive for HIV. [*Inmate charged with exposing jailer to HIV*, WKRN.com, Nov. 8, 2010, http://www.wkrn.com/Global/story.asp?S=13466403; Chris Graham, *Family Disputes HIV Charge*, The Daily Herald, Nov. 10, 2010]
Nov. 2010	MO	Spitting	Assault	A man who claims he has HIV was charged with two counts of assault for allegedly threatening and spitting on police officers. [Kathryn Wall, *Man claiming he has HIV charged in assault on officers*, News-Leader.com, Nov. 2, 2010, http://www.news-leader.com/article/20101102/NEWS01/11020343/Man-claiming-

				he-has-HIV-charged-in-assault-on-officers]
Oct. 2010	TN	Sex	Criminal Exposure of Another to HIV	A man was charged with five counts of criminal exposure of HIV after allegedly failing to tell three of his sexual partners that he had HIV. Two of the counts were eventually dismissed. One of the women tested positive for HIV. The man pleaded guilty to three counts of criminal exposure to HIV and was sentenced to six years of probation. [Claire Galofaro, *Bristol man sentenced to six years probation for knowingly exposing women to HIV,* TriCities.com, May 23, 2011, http://www2.tricities.com/news/2011/may/23/bristol-man-sentenced-six-years-probation-knowingl-ar-1059542/; Kacie Breeding, *Bristol Man Sentenced for Exposing Women to HIV,* Timesnews.net, May 23, 2011, http://www.timesnews.net/article.php?id=9032324; Kacie Breeding, *Case of Bristol man accused of exposing women to HIV postponed*, Timesnews.net, Jan. 28, 2011, http://www.timesnews.net/article.php?id=9029413; Claire Galofaro, *"Flipper" Sensabaugh indicted on charges of criminal exposure to HIV*, TriCities.com, Oct. 29, 2010, http://www2.tricities.com/business/2010/oct/29/flipper-sensabaugh-indicted-charges-criminal-expos-ar-614364/]
Oct. 2010	VA	Sex	Infected Sexual Battery	A man was charged with a class 6 felony for allegedly knowingly exposing women to HIV. [*Man accused of infecting women with HIV*, WTVR.com, Oct. 15, 2010, *available at* http://www.wtvr.com/news/wtvr-man-infecting-women-with-hiv-101410,0,2366386.story]
Oct. 2010	WA	Sex	First Degree Assault	A 19-year-old male college student was charged with first degree assault for having sex with girlfriend without allegedly disclosing his HIV status. [*HIV-Infected Man Faces Assault Counts*, KHQQ6.com, Oct. 13, 2010] The search warrant issued for the young man's medical records were quashed and the HIV related charges were dismissed.
Oct. 2010	WA	Sex	First Degree Assault	A 23-year-old HIV positive man was sentenced to 87 months imprisonment after pleading guilty to first degree assault charges. The man engaged in anonymous, unprotected, and undisclosed sex with a man that he met on manhunt.com. [*HIV positive man sentenced for assault*, The Spokesman Review, Oct. 12, 2010, available at http://www.spokesman.com/stories/2010/oct/12/hiv-positive-man-sentenced-assault/]
Oct. 2010	OH	Sex	Felonious Assault	A man was charged with felonious assault for allegedly failing to tell his wife that he was HIV positive. When the man was admitted to the hospital with pneumonia his doctor allegedly threatened to tell the man's wife about his HIV status if the man didn't. [Tom Giambroni, *Husband Allegedly kept HIV a secret*, Morning Journal, Oct. 2, 2010, available at http://www.morningjournalnews.com/page/content.detail/id/526618/Husband-allegedly-kept-HIV-a-secret.html?nav=5006]
Oct. 2010	TX	Sex	Super aggravated assault (HIV as a deadly weapon)	A 32-year-old HIV-positive Iraq war veteran was sentenced to three life sentences without parole for super aggravated assault of a child and continuous sexual abuse of a child. A super aggravated assault conviction requires that the jury find that the defendant used a deadly weapon, in this case HIV, during the assault. [Craig

				Kapitan, *HIV Molester Handed three life sentences*, Express News, Oct. 7, 2010, available at http://www.mysanantonio.com/news/local_news/molester_with_hiv_gets_life_without_parole__times_three_104532769.html?c=y&page=1#storytop]
Sept. 2010	CA	Sex	Unprotected sexual activity with the intent to expose another to HIV	A 41-year-old HIV-positive man pleaded guilty to intentionally exposing his sexual partner to HIV. [Tomoya Shimura, *Gang Member Pleads Guilty to Spreading HIV*, Highdesert.com, Sept. 7, 2010, available at http://www.highdesert.com/articles/spreading-21626-vvdailypress-gang-victorville.html]
Sept. 2010	UT	Sex	Enhanced penalties for HIV positive offenders	An HIV-positive sex worker was sentenced to five years imprisonment after pleading guilty to one count of third degree felony solicitation. The woman had tested positive for HIV in 2007 after her fourth prostitution conviction. She had also been imprisoned in 2008 and 2009 for prostitution. [Stephen Hunt, *HIV Positive Prostitute Sent to Prison*, Salt Lake Tribune, Sept. 17, 2010, http://archive.sltrib.com/article.php?id=11176194&itype=storyID]
July 2010	MD	Spitting	Second Degree Assault	A 44-year-old HIV positive man was sentenced to five years in prison for spitting on a police officer. Because the defendant had no teeth and often spat unintentionally it is not clear whether the man intended to spit on the police officer. [Don Aines, *Man with HIV who Spit on Police Officer Sentenced to Five Years*, Herald-Mail (Hagerstown, MD), July 26, 2010, http://www.herald-mail.com/?cmd=displaystory&story_id=249796&format=html&autoreload=true.]
June 2010	IN	Sex	"Duty to Warn Statute" Class D felony	A 19-year-old woman was charged with failing to disclose her HIV status to her 22-year-old sexual partner. In Sept. 2010 she pleaded guilty and was originally sentenced to 222 days imprisonment but eventually had the prison time negated. As part of her probation, she must complete sex offender counseling, avoid internet use, and not possess any pornography. [*No prison for teen's lie about HIV, sex*, JCOnline.com, Oct. 13, 2010, http://www.wthr.com/global/story.asp?s=12655922]
May 2010	OK	Spitting	Spreading Infectious Disease and Knowingly Engaging to Transfer HIV	A man claiming to be HIV-positive was booked on four felony complaints after moving his head to throw blood at emergency medical workers. He is also alleged to have spit blood at the workers during his rescue and treatment for injuries from a fire. [Shannon Muchmore, *Man Who Says He Has HIV Allegedly Spits on Emergency Workers*, Tulsa World, May 23, 2010, http://www.tulsaworld.com/news/article.aspx?subjectid=11&articleid=20100523_298_0_Amanwh547994]
May 2010	AR	Spitting	Aggravated assault and exposing another to HIV.	A 41-year old, HIV+ man was arrested after spitting blood at a police officer. He is currently facing charges of aggravated assault and exposing another to HIV. [Gavin Lesnick, *HIV-positive Man Spits Blood at Police Officer*, *report says*, ArkansasOnline.com, May 12, 2010, http://www.arkansasonline.com/news/2010/may/12/hiv-positive-man-spits-blood-officer-report-says/?latest]
May 2010	MI	Biting	Bioterrorism	A HIV+ man was charged with bioterrorism for biting his neighbor during an argument. The man eventually pleaded guilty to an assault charge and was given probation by the judge. [*HIV-positive man tied to bioterrorism charge gets probation*, Free Press,

				Christina Hall, Dec. 8, 2010, http://www.freep.com/article/20101208/NEWS04/101208026/1320/HIV-positive-man-sentenced-in-biting]
Mar. 2010	TX	Sex	Aggravated Sexual Assault of a child.	A 49-year-old HIV+ man, who was aware of his HIV status, was charged with having unprotected sex with a minor. The charge became "aggravated" because of his HIV status, making it a felony. [Houston Chronicle 3/22/10, http://www.chron.com/news/houston-texas/article/In-1st-for-Harris-Co-HIV-deemed-deadly-weapon-1714831.php]
Mar. 2010	MN	Sex	Assault	A 28-year-old HIV+ man was charged with assault after failing to tell his partners his HIV status prior to having unprotected consensual sex. One partner tested positive for HIV. [Star Tribune 3/24/10]
Mar. 2010	AR	Sex	Knowingly Exposing Another to HIV	A 33-year-old HIV+ man was arrested for having unprotected sex with a woman, knowing he had HIV, and failing to inform her of his illness. Woman has now tested positive for HIV. Pled not guilty; sentenced to 20 years in prison. [Times Record Online 3/11/10, http://www.swtimes.com/news/article_65cead58-2a9f-51f9-b9be-3fd6c779af14.html]
Mar. 2010	MI	Sex	Failing to Disclose HIV Status to Sexual Partner	A 54-year-old HIV+ woman allegedly failed to tell her sexual partner that she had HIV. She was sentenced to 11 months in prison. [The Michigan Messenger 3/11/10] http://michiganmessenger.com/35670/isabella-county-woman-charged-with-failing-to-disclose-her-hiv-positive-status-to-sex-partner
Mar. 2010	MD	Sex	Knowingly Exposing Others to HIV	A 29-year-old HIV+ man was sentenced to 18 months in prison after he knowingly exposed an 18-year-old woman to the HIV virus. [Gazette.net 3/10/10]
Mar. 2010	NJ	Sex	Third Degree Diseased Person Charge (HIV Specific)	A 20-year-old HIV+ man charged with having "high risk sexual behavior" with a female without her informed consent. [LehighValleyLive.com 3/10/10]
Mar. 2010	OH	Sex	Loitering to Engage in Sexual Activity Being HIV Positive and Soliciting with Previous Conviction Being HIV Positive	A 38-year-old HIV+ woman was charged with attempted solicitation. [Chicago Tribune 3/10/10]
Mar. 2010	IN	Donating Plasma	Donating Plasma when Knowing HIV+ Status	A 39-year-old HIV+ woman plead not guilty to donating plasma in 2008, though she had been diagnosed with HIV since 2005. [Chicago Tribune 3/9/09]
Feb. 2010	FL	Sex	Failing to Disclose HIV Status to Sexual Partner	A 45-year-old HIV+ man pleaded not guilty to a first degree felony charge for allegedly failing to tell his sexual partner that he was HIV position. [POZ 2/24/10]
Feb. 2010	IN	Sex	Failure of Carriers Duty to Warn	A 47-year-old HIV+ man had sexual relations with several woman without telling them he was HIV+. He plead guilty to two counts, and was sentenced to 18 months on Dec. 12, 2011. He will be sentenced for another 14 counts in Feb. 2012. [http://www.abc57.com/video/Indiana-man-behind-bars-for-infecting-partners-with-HIV-135545753.html]
Dec. 2009	IA	Sex	Criminal Transmission of HIV (transmission need not occur)	A 38-year-old HIV+ man was charged with a felony after he allegedly failed to tell his sexual partner is HIV status. [wcfcourrier.com 12/23/09]

Nov. 2009	MI	Sex	AIDS-sexual penetration with an Uninformed Partner	A 21-year-old HIV+ man had consensual sexual relations; pled guilty and sentenced to 9 months in jail. [Midland Daily News 11/18/2009]
Nov. 2009	SC	Sex	Knowingly Exposing Another to HIV	A man was sentenced for knowingly exposing his wife to HIV; sentenced to 6 years in prison. Wife did not contract HIV. [The Augusta Chronicle 9/14/09]
Nov. 2009	TX	Sex	Aggravated sexual assault with deadly weapon	A 26-year-old man was charged with aggravated sexual assault with deadly weapon (HIV being the deadly weapon) after allegedly having unprotected sex with a 16-year-old. [http://www.kxxv.com/Global/story.asp?S=11436836] He pleaded guilty in June 2010, and received a 15 year prison sentence in August 2010. [http://www.kxxv.com/global/story.asp?s=12977817]
Oct. 2009	SC	Sex	Knowingly Exposing Another to HIV	A 24-year-old HIV positive man exposed another to HIV. [WMFBNews.com 10/27/09]
Oct. 2009	PA	Spitting	Aggravated Assault (HIV and prisoner specific)	A HIV and Hepatitis C positive woman was charged after she spit in the face of another inmate; sentenced to 21 months to 10 years in prison. [citizensvoice.com 10/15/09] [Wyoming County Press Examiner 9/9/09]
Oct. 2009	VA	Sex	Aggravated Assault (HIV Specific). Court Martial (Military)	Two women, including ex-wife, chose to have consensual, unprotected sex with a Military Officer, knowing that he had HIV. The man was sentenced to 3 months in confinement and a bad conduct discharge after pleading guilty to two counts of aggravated assault and disobeying an order. The order was for him to have sex only with the use of protection. Neither woman contracted HIV. [Virginian Pilot 10/7/09]
Sept. 2009	IL	Sex	Criminal Transmission of HIV	A 42-year-old HIV+ man had sex with a 19-year-old woman with allegedly failing to inform the woman that he was HIV+. Unknown if the woman has tested positive for HIV. Criminal statute applies even if the sex partner is not subsequently infected with HIV. [Journal Gazette Times Courier 9/21/09] Pled Guilty; sentenced to 6 years in prison. [Herald Review 2/6/10]
Sept. 2009	ID	Sex	Knowingly Exposing Another to HIV	A 44-year-old HIV+ man pleaded guilty to two felony charges of exposing women to HIV. Sentenced to 30 years in prison with the possibility of parole after 20 years. At least one woman was not infected with HIV. [Idahostatesman.com 9/17/09]
Sept. 2009	OH	Sex	Loitering to Engage in Prostitution with the Knowledge that He/She Has Tested Positive for HIV	A 25-year-old HIV+ man was arrested for prostitution. It was later discovered that the man knew he was HIV positive. [Dayton Daily News 9/11/09]
Sept. 2009	SC	Sex	Knowingly Engaging in Sexual Intercourse without Disclosing HIV Status	A 35-year-old HIV+ man had sexual relations with a woman without telling her that he was HIV positive. [WMBFNews.com 9/11/09].
Sept. 2009	TN	Spitting	Criminal Exposure to HIV	A HIV+ man spit blood at a police officer while being arrested for burglary. [Chicago Tribune 9/4/09] [myeyewitnessnews.com 9/3/09]
Aug. 2009	GA	Biting	Aggravated Assault	A 42-year-old, HIV+ man was sentenced to 18 months for aggravated assault after he bit an Atlanta police officer. He allegedly shouted "I have full-blown AIDS" and bragged that he had infected the officer. The police officer did not test positive for HIV.

				[Stephanie Ramage, *Too Lenient?*, SundayPaper.com, Aug,. 30, 2009, http://www.sundaypaper.com/DesktopModules/DnnForge%20%20NewsArticles/Print.aspx?tabid=98&tabmoduleid=940&articleId=4452&moduleId=922&PortalID=0]
Aug. 2009	FL	Biting	Aggravated battery on a law enforcement officer (not HIV-specific) [Originally charged with attempted murder]	35-year-old HIV+ man bit a police officer and drew blood while trying to avoid being arrested; officer tested negative; sentenced to 15 years. [Miami Herald 8/26/09]
Aug. 2009	FL	Sex	Committing Prostitution while HIV Positive (3rd Degree Felony with possibility of maximum of 5 years in prison)	A 32-year-old woman was arrested for working as a prostitute while she knew she was HIV positive. [Palm Beach Post 8/21/09]
Aug. 2009	FL	Sex	Failing to Inform a Sexual Partner of One's Known HIV Status	A 39-year-old HIV+ woman was arrested for having unprotected sex with a man without disclosing her HIV status. [Ocala.com 8/14/09]
Aug. 2009	MN	Sex	Knowing transfer of communicable disease	39-year-old HIV+ man had sex with girlfriend w/o disclosing his HIV status; girlfriend tested negative; ex-wife tested positive[Duluth News Tribune 8/11/09]; pled guilty; sentenced to 90 days in jail. [POZ Magazine 10/29/09]
July 2009	AR	Sex	Knowing exposure to HIV	A 29- year-old man was arrested for raping a child and knowingly exposing the child to HIV. http://www.fox16.com/news/local/story/Man-charged-with-knowingly-exposing-child-to-HIV/Bn1fSMFQ5UCN9yFeHO1H0Q.cspx
July 2009	SC	Biting	Assault and Intent to Kill	A 41-year-old HIV-positive man was charged with assault and intent to kill after biting his neighbor. An original charge of simple assault was upgraded after it was discovered that the assailant was HIV-positive. This case is pending. [Greg Suskin, *Charges Upgraded Against HIV Positive Man After Fight,* wsoctv.com, July 29, 2009, http://www.wsoctv.com/news/20147162/detail.html]
July 2009	WA	Sex	Assault (HIV-specific)	An HIV+ man had unprotected sex with other men w/o disclosing his HIV status; pending. [The Spokesman-Review 7/15/09]
July 2009	OR	Sex	Assault and attempted assault (not HIV-specific)	21-year-old HIV+ man had unprotected sex with woman w/o disclosing his HIV status; pled guilty; woman tested positive for HIV; sentenced to 2 yrs in prison, 3 yrs post-prison supervision, sex offender evaluation [The Oregonian 7/17/09]
July 2009	VT	Spitting	Aggravated assault against a police officer	31-year-old HIV+ man spat on police officer while being restrained for treatment after police responded to possible drug overdose; pending [Times Argus 7/30/09]
June 2009	KS	Sex	Exposing another to a life-threatening communicable disease	Kansas Supreme Court reversed convictions for exposing another to a life-threatening communicable disease, finding that the prosecution failed to prove that defendant intended to expose the complainants to HIV. [State v. Richardson, 209 P.3d 696 (Kan. 2009)]
June 2009	NC	Biting	Assault inflicting serious bodily injury & assault with a deadly weapon	A 45-year-old HIV+ man cut a police officer's thumb and bit the police officer's ear during an altercation; pending [*Man Used His HIV as weapon, police sa*y, News and Observer, June 21, 2009, http://www.newsobserver.com/2009/06/22/81920/man-used-his-hiv-as-weapon-police.html#storylink=misearch]

June 2009	NY	Spitting	Aggravated assault on a police officer by means of a deadly weapon (saliva)	HIV+ man allegedly spat on police officer while being subdued for erratic behavior after learning HIV diagnosis; took 10-year plea deal & reserved right to appeal; appeal pending [Information from defendant and defense counsel]
June 2009	OH	Spitting	Harassment by inmate (HIV-specific; not limited to inmates)	HIV+ man spat on police officer and EMT while being subdued for erratic behavior after suicide attempt; attorney challenged validity of statute; pled no contest; sentenced to 60 days house arrest in Sept. 2009 [Information from defense counsel]
May 2009	AR	Sex	Knowingly transmitting AIDS, HIV	HIV+ teenage boy had sex with teenage girl w/o disclosing his HIV status; being tried as an adult; pending [4029tv.com 5/19/09]
May 2009	OH	Sex	Felonious assault (HIV-specific)	HIV+ man had sex with woman without disclosing his HIV status; appeal pending; attorney challenged constitutionality of statute [Information from defense counsel]
May 2009	TX	Sex	Aggravated assault (not HIV-specific). Assault with a deadly weapon.	53-year-old HIV+ man had sex with multiple women w/o disclosing HIV status; at least 6 women tested positive for HIV [Dallas Morning News 5/28/09]; sentenced to 5 45-yr and 1 25-yr prison terms [Dallas Morning News 5/30/09] http://abcnews.go.com/2020/story?id=7696939&page=1
May 2009	FL	Sex	Unlawful acts (HIV-specific)	HIV+ woman had sex with multiple men w/o disclosing her HIV status; pending [Orlando Sentinel 5/8/09]
May 2009	IA	Sex	Criminal transmission of HIV (transmission need not occur)	HIV+ man had sex one time with man he met online; was under influence of drugs during sex; not clear if condom was used; other man not HIV+ after testing; received 25-year sentence & must register as sex offender [wcfcourier.com 5/2/09]; later released on 5 yrs probation after reconsideration hearing on Sept. 11, 2009 [accesslineiowa.com 9/14/09]; the HIV+ man is now listed as a sex offender.
April 2009	MI	Sex	Sexual penetration w/ knowledge of AIDS or HIV infection	An HIV+ woman employed at a sex club had sex w/ multiple partners w/o disclosing her HIV status; [Michigan Live 4/29/09]; sentenced to 16 mos. to 20 yrs [Niles Daily Star 9/22/09]
Jan. 2009	GA	Sex	Reckless conduct by HIV infected persons	38-year-old HIV+ man had sex with a woman w/o disclosing his HIV status; woman agreed to unprotected sex with man who lived in housing program for people with HIV; woman tested negative; pled guilty; sentenced to 2 yrs in prison and 8 yrs probation [macon.com 1/13/09]
Dec. 2008	MI	Sex	Failing to Disclose HIV Status to Sexual Partners	A 38-year-old HIV+ woman pled guilty to failing to inform her sexual partners of her HIV status. She was sentenced to time already served, 68 days. [mlive.com 12/10/08]
Dec. 2008	CO	Sex	Child abuse resulting in serious injury (not HIV-specific)	33-year-old HIV+ man had sex with pregnant fiancée w/o disclosing his HIV status; both mother and baby tested positive for HIV [GJSentinel.com 12/23/08]; sentenced to 15 yrs in July 2009 [GJSentinel.com 7/18/09]
Dec. 2008	NE	Sex	Manufacturing child pornography (not HIV-specific)	48-year-old HIV+ man had consensual sex with 17-year-old boy w/o disclosing his HIV status; videotaped sexual encounter; boy tested positive for HIV; sentenced to 20 years (cut to 10 per state sentencing guidelines) [Omaha World Herald 12/22/08]
Oct. 2008	OK	Biting	Knowingly Engaging to Transfer HIV	A 50-year old, HIV-positive woman was arrested in October 2008 after biting a security guard and attempting to spread the virus. The outcome of this case is unknown. [Jay Marks, *HIV-positive Woman Faces Felony for Bite,* NewsOk, Oct. 8, 2008, http://newsok.com/hiv-positive-woman-faces-felony-for-

				bite/article/3308838]
Oct. 2008	MS	Sex	Endangerment by bodily substance (HIV-specific)	HIV+ African-American woman had sex with white husband over many years w/o disclosing her HIV status; husband alerted police when woman tried to get custody of son in divorce proceeding; husband and son both tested negative; pled guilty; 10-year sentence w/ 9 suspended; one year house arrest [Clarion Ledger 5/16/08, 10/7/08]
Oct. 2008	KY	Sex	Rape; Sodomy	The Kentucky Supreme Court held that a defendant's HIV status may be considered during the sentencing portion of a trial. [Torrence v. Commonwealth, 269 S.W.3d 842 (Ky. 2008)]
Sept. 2008	GA	Sex	Reckless Conduct	A woman was sentenced to 8 years imprisonment for failing to disclose her HIV status to her sexual partners. She argued that her sexual partner must have known of her HIV status because it had been published on the front page of the local newspaper. [Ginn v. State, 667 S.E.2d 712 (Ga. Ct. App. 2008)]
Sept. 2008	MI	Sex	Sexual penetration w/ knowledge of AIDS or HIV infection	A 32-year-old HIV+ man had sex with two women w/o first disclosing his HIV status; HIV status of women unknown. [mlive.com 9/5/08] He was sentenced to 2 months in jail. [mlive.com 2/3/09]
Aug. 2008	NC	Sex	Charges Related to Controlling the Spread of HIV	A 23-year-old, HIV+ man was sentenced to 30 months of probation for having unprotected sex with numerous partners. He was later sentenced to six months of house arrest for further acts of unprotected sex. [*Gay DJ put on house arrest for second HIV violation*, Wral.com, Oct. 21, 2008, http://www.wral.com/news/news_briefs/story/3781930/]
Aug. 2008	FL	Biting	Criminal Transmission of HIV	A 25-year-old woman was sentenced to 5 years in prison for battery on a law enforcement officer, and resisting arrest with violence, with increased penalties because a Florida law makes it a third degree felony for HIV positive defendants to transfer body fluids during a violent act. She reacted violently while being arrested. She was diagnosed with cancer four months into her sentence, and after a prolonged public campaign was released in January 2011 to die at home. [http://www.miamiherald.com/2011/01/06/2002703/dying-broward-inmate-granted-conditional.html]
Aug. 2008	NH	Spitting	Simple assault	24-year-old man of unknown HIV status spat in police officer's face; sentenced to 2-5 yrs in prison; required to pay for officer's HIV test and apologize to officer [The Citizen of Laconia 8/11/08]
July 2008	GA	Spitting	Aggravated assault (not HIV-specific)	43-year-old HIV+ woman spat in face of other person; allegedly yelled, "I hope you get AIDS"; sentenced to 3 yrs [Ledger-Enquirer 7/22/08]
June 2008	MD	Biting	Knowingly transfer or attempt to transfer HIV	44-year-old HIV+ man bit police officer while being arrested on warrant; officer tested negative for HIV; sentenced to 18 years [gazette.net 6/4/08]
June 2008	ID	Sex	Transferring body fluids containing HIV	An HIV+ man was convicted of transferring body fluids containing HIV after he performed oral sex on complainant. The court refused to take into consideration evidence of the scientific unlikelihood of HIV transmission through male-to-female oral sex. [State v. Mubita, 188 P.3d 867 (Idaho 2008)]
May 2008	TX	Spitting	Harassing a public servant (not HIV-specific) with deadly weapon (saliva)	42-year-old HIV+ homeless man spat on police officer during arrest for public intoxication; sentenced to 35 years (25-year minimum under habitual offender law); must serve at least half because of

				deadly weapon finding; waived right to appeal [NY Times 5/16/08, information from defense counsel]; Unpublished decision on appeal of deadly weapon finding (denied), 2009 WL 2025344 (Tex. App. 2009)
May 2008	TX	Biting	Aggravated robbery (not HIV-specific)	26-year-old HIV+ man bit security guard after being stopped for shoplifting; outcome unknown [nbc5i.com 5/31/08]
May 2008	AR	Sex	Knowingly transmitting AIDS (text of statute refers to exposure)	33-year-old HIV+ man had sex with girlfriend and another woman w/o disclosing his HIV status; both women tested negative for HIV; sentenced to 12 years and must register as sex offender [The Morning News 5/1/08]
April 2008	KY	Biting	Wanton endangerment (not HIV-specific)	HIV+ woman bit store clerk while robbing store; clerk tested negative for HIV; sentenced to 12 years total, 2 of which was for wanton endangerment [*HIV-Positive Robber Receives 12 year prison sentence*, wkytv.com, April 8, 2008, *available at* http://www.wkyt.com/home/headlines/17382524.html]
Mar. 2008	SC	Sex	Exposing others to HIV	39-year-old HIV+ man had sex with girlfriend w/o disclosing his HIV status; girlfriend tested positive for HIV during prenatal visit; pled guilty; sentenced to 4 years [goupstate.com 3/21/08]
Feb. 2008	MO	Sex	Prohibited acts (HIV-specific)	43-year-old HIV+ man had sex with a woman w/o disclosing his HIV status; outcome unknown [kspr.com 2/12/08]
Jan. 2008	KS	Sex	Exposing another to a life threatening communicable disease (not HIV-specific)	HIV+ man had sex with two women w/o disclosing his HIV status; defendant thought he posed no risk b/c infection was "under control" w/ meds; both women tested negative for HIV; sentenced to 32 months for each of two counts [Emporia Gazette 1/17/08]; *conviction reversed by Kansas Supreme Court on 6/19/09 on specific intent issue, State v. Richardson, 209 P.3d 696 (Kan. 2009)*

HIV CRIMINALIZATION FACT SHEET

MOST STATES HAVE TARGETED HIV-POSITIVE INDIVIDUALS FOR CRIMINAL LIABILITY BASED ON THEIR HIV STATUS

- Thirty-four (36) states and two (2) U.S. territories explicitly criminalize HIV exposure through sex, shared needles or, in some states, exposure to "bodily fluids" that can include saliva. At least thirty-five (35) states have singled out people who have tested positive for HIV for criminal prosecution or enhanced sentences, either under HIV-specific criminal laws or under general criminal laws governing crimes such as assault, attempted murder or reckless endangerment.
- Proof of intent to transmit HIV, or actual transmission, typically are not elements of these prosecutions.
- Spitting and biting, which pose no significant risk of HIV transmission, have resulted in criminal convictions and severe sentences despite the absence of HIV transmission in these cases.
- Disclosure is often the only affirmative defense to prosecution, but typically is difficult to prove. Condom use is rarely a defense.
- The common factor in all of these cases is that the criminal defendant knew her/his HIV status.
- Also common to these cases is severe ignorance of the routes and actual risk of HIV transmission in varying circumstances, and grossly exaggerated characterizations of the risk of harm defendants pose.

CRIMINALIZATION HAS NO EFFECT ON BEHAVIOR & UNDERMINES PUBLIC HEALTH GOALS

- Studies show that the criminalization of HIV exposure has no effect on risk behavior.
- HIV criminalization can discourage individuals from seeking testing and treatment because a positive test result subjects a person to criminal liability for otherwise non-criminal conduct.
- Health care providers frequently are forced to disclose HIV-related medical records, including documentation of private communications, as part of a criminal investigation or trial, interfering with the physician-patient relationship and delivery of health services and generating mistrust among patients.
- In some states, health officials actually participate in creation of evidence that can be used against individuals with HIV, by requiring them to sign forms acknowledging criminal liability if they engage in certain otherwise-legal conduct.
- Sex between two consenting adults is a shared decision; the responsibility for protection against disease should not be borne by one partner. Placing exclusive responsibility on the person living with HIV undermines public health messages that everyone should take responsibility for individual sexual health.
- Criminalization further stigmatizes an already marginalized population, and reinforces ignorance and unfounded beliefs about the routes and actual risks of HIV transmission.

HIV PROSECUTIONS DISCRIMINATE AGAINST HIV-POSITIVE PERSONS

- Charges for HIV exposure often are accompanied by sensationalist media coverage, which often includes disclosure of the HIV-positive person's identity, disclosing the person's HIV status not only to the individual's community but also, with the internet, to the world.
- Sentences for people convicted of HIV exposure are typically very harsh and grossly disproportionate to any actual or potential harm, perpetuating the misconception that people with HIV are toxic, highly infectious and dangerous.
- HIV-positive persons increasingly are forced to register as sex offenders after conviction, leading to a host of life-long problems with future employment, living conditions, and the right to privacy.

- HIV exposure laws are applied unfairly and selectively, targeting those who are socially and economically marginalized, such as sex workers, while those with other STIs or infectious diseases are not targeted.

The chart below presents data comparing HIV infection to other sexually transmitted infections. These data illustrate that other sexually transmitted infections can pose similar, and sometimes equally great or greater, risks than HIV. Herpes simplex virus type 2 (HSV-2) and human papilloma virus (HPV) are more prevalent than HIV. Gonorrhoea and HPV are far more easily transmissible than HIV during unprotected sexual activity. Like HIV, HSV-2 is not curable. Potential consequences of HPV, gonorrhoea, and HSV- 2 include cancer, pelvic inflammatory disease, infertility, and infant death.

HIV, STIs and Relative Risks in the United States

Disease	Prevalence	Associated Risk of Transmission	Infection Outcomes
HIV	• 0.6%[1]	• Infection rate per sexual exposure to HIV:[2] • Receptive vaginal intercourse: 0.10% • Insertive vaginal intercourse: 0.05% • Receptive oral intercourse: 0.00-0.04% • Insertive oral intercourse: ~0.00% • Receptive anal intercourse: 1.40% • Insertive anal intercourse: 0.065%	• HIV is not curable[3] • Untreated HIV infection will almost inevitably lead to illness and premature death[4] • HIV can be managed as a chronic disease through the use of HAART[5,6] • HIV-positive individuals can experience a near-normal life span with early detection and treatment [7]
Human Papilloma Virus (HPV)	• Low-risk and/or high-risk types: 26.8%[8]	• Median transmission estimate for low- and high-risk types: 40.0% per heterosexual contact[9] • Transmission rate of the 14 high-risk types of HPV: 43.0%–94.0% per average relationship between discordant heterosexual partners[10]	• There are more than forty types of HPV, classified as low-risk or high-risk based on strength of association with cervical cancer[11] • High-risk HPV types cause 99% of cervical cancer cases, as well as anal and other genital cancers[12] • The advent of HPV screening and prevention technology has greatly reduced the number of cervical cancer deaths in high-income countries[13] • In 2007, 4,021 women died of cervical cancer in the United States[14] • Cervical cancer ranks in the top 10 most prevalent cancers among Black, Hispanic, American Indian and Alaska Native women in the United States[15]
Gonorrhoea	• 105.5 cases in women per 100,000 population • 91.9 cases in men per 100,000 population[16]	• Estimated female to male transmission rate per sexual contact: 25.0%[17] • Estimated male to female transmission rate per sexual contact: 50.0%[18]	• Gonorrhoea is treatable with antibiotics[19] • Treating gonorrhoea continues to become more difficult as drug resistance grows – Cephalosporins, currently in use, are the fourth line of treatment for gonorrhoea infection[20] • The Centers for Disease Control (CDC) now recommends dual therapy for gonorrhoea utilizing a cephalosporin and either azithromycin or doxycycline[21] • Untreated gonorrhoea can cause pelvic inflammatory disease, ectopic pregnancy, and infertility[22] • Untreated gonorrhoea can increase susceptibility to human immunodeficiency virus (HIV) infection[23]
Herpes Simplex Virus Type 2 (HSV-2)	• 16.2% overall population prevalence[24]	• Male to female transmission rate per sexual contact: .089%[25] • Female to male transmission rate per sexual contact: .015%[26]	• HSV-2, like all other types of herpes, is not curable[27] • Can cause repeated outbreaks of genital sores and lead to infant death if acquired during pregnancy[28] • Can increase susceptibility to HIV infection and can increase infectiousness of HIV-positive individuals[29]

[1] *Id* at 202.
[2] Fox J, et al. Quantifying sexual exposure to HIV within an HIV-serodiscordant relationship: development of an algorithm. *AIDS*. 2011;25:1065.
[3] Basic Information about HIV and AIDS. United States Centers for Disease Control and Prevention. http://www.cdc.gov/hiv/topics/basic/index.htm
[4] Broder S. The development of antiretroviral therapy and its impact on the HIV-1 AIDS pandemic. *Antiviral Research*. (2010).
[5] Ibid
[6] http://www.hab.hrsa.gov/tools/primarycareguide/index.htm
[7] National and local guidelines on the recommended time to start treatment can vary but most high-income guidelines currently recommend treatment at a CD4 count < 350-500 cells/mm3;
Lewden C and the Mortality Working Group of COHERE. Time with CD4 count above 500 cells/mm3 allows HIV-infected men, but not women, to reach similar mortality rates to those of the general population: a 7-year analysis. Seventeenth Conference on Retroviruses and Opportunistic Infections, San Francisco, abstract 527, 2010. (Reported on Aidsmap.com);
Van Sighem A et al. Life expectancy of recently diagnosed asymptomatic HIV-infected patients approaches that of uninfected individuals. Seventeenth Conference on Retroviruses and Opportunistic Infections, San Francisco, abstract 526, 2010. (Reported on Aidsmap.com);
May M et al. Impact on life expectancy of late diagnosis and treatment of HIV-1 infected individuals: UK CHIC.
[8] Prevalences were among women age 14-59. Prevalence of low-risk types was 15.2%, prevalence of high-risk types was 17.8%. Some women were infected with both low-risk and high-risk types. Dunne EF, Unger ER, Sternberg M, McQuillan G, Swan DC, Patel SS, et al. Prevalence of HPV infection among females in the United States. *Journal of the American Medical Association*. 2007:297(8):813-9. http://jama.ama-assn.org/content/297/8/813.full
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[20] Ibid
[21] Ibid
[22] Fleming D, Wasserheit J. From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Sex Trans Infect* 1999:75;3--17.
[23] Ibid
[24] Prevalence among men and women age 14-49.
Genital Herpes - CDC Fact Sheet. United States Centers for Disease Control and Prevention. http://www.cdc.gov/std/herpes/STDFact-Herpes.htm
[25] Wald A, Langenberg AGM, Link K, et al. "Effect of Condoms on Reducing the Transmission of Herpes Simplex Virus Type 2 From Men to Women." JAMA 2001; 285:3100-3106.
[26] Ibid
[27] Genital Herpes - CDC Fact Sheet.
[28] Ibid
[29] Ibid

Transmission Routes, Viral Loads and Relative Risks:
The Science of HIV for Lawyers and Advocates

The Center for HIV Law and Policy • 65 Broadway, Suite 832 • New York, New York 10006
212-430-6733 phone • 212-430-6734 fax • info@hivlawandpolicy.org • www.hivlawandpolicy.org

MISSION STATEMENT

The Center for HIV Law and Policy is a national legal and policy resource and strategy center for people with HIV and their advocates. CHLP works to reduce the impact of HIV on vulnerable and marginalized communities and to secure the human rights of people affected by HIV.

We support and increase the advocacy power and HIV expertise of attorneys, community members and service providers, and advance policy initiatives that are grounded in and uphold social justice, science, and the public health.

We do this by providing high-quality legal and policy materials through an accessible web-based resource bank; cultivating interdisciplinary support networks of experts, activists, and professionals; and coordinating a strategic leadership hub to track and advance advocacy on critical HIV legal, health, and human rights issues.

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To contact us:
Email us at info@hivlawandpolicy.org.

Or write to:
The Center for HIV Law and Policy
65 Broadway, Suite 832
New York, NY 10006
212.430.6733
212.430.6734 fax

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Beirne Roose-Snyder, Staff Attorney
Catherine Hanssens, Executive Director
July 2011

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I. INTRODUCTION

A lawyer dropped into the world of HIV/AIDS through a criminal or civil case can feel like they have fallen through the looking glass. There are T cells and viral loads and antiretrovirals, as well as often bizarre standards for intent and a confusing relationship between health and law enforcement.

This document seeks to set out both the basic science of HIV, and to present current research and scholarship in ways that are accessible and usable for lawyers and advocates. Criminal prosecutions for HIV related crimes are premised on a number of public health, scientific, and legal foundations that do not bear up under serious scrutiny and current research. And similarly in civil cases of housing or employment discrimination, or in protecting the rights of HIV-positive pregnant women, the use of good scientific research and support can be the difference between winning and losing a case for your client.

This document addresses misconceptions and arguments that we have found are often missing from HIV related legal cases. The content is organized by key arguments or bodies of research that, while well established, have not easily made the jump from scholarship to the courtroom.

First, this introduction will establish some vocabulary, and discuss how it comes up in legal proceedings. Second, the section on *HIV as a Chronic Condition* will provide citations and abstracts for the established proposition that HIV is a chronic, treatable condition and not the "death sentence" that it is so often referred to in court opinions. Third, the section on *HIV as a Covered Disability under the ADAAA* offers language to support HIV as an immune disorder for purposes of disability analysis. Fourth, the section *HIV Transmission and Relative Risks* presents the research on the relative transmission risks of different types of sexual and non-sexual contact. The fifth section, *Viral Load and Treatment*, consists of research on how low viral loads, which are often supported by antiretroviral treatment, make HIV transmission risks much lower. The final section, *Phylogenetic Analysis*, contains information about the use and limitations of comparing different viral strains in "proving" HIV transmission.

For those lawyers handling HIV criminalization cases, understanding the science of HIV and how it conflicts with the rationales of HIV-specific criminal prosecutions is only one piece of the argument. It may also be useful to have citations to documents that support decriminalization or call in to question the foundations of criminalization. We have created a *Policy Statements and Support for Decriminalization* supplement, which presents national and international statements and selected articles that lay out arguments against the exceptional treatment of HIV in law, and provide supporting quotes that can be useful in writing briefs and other court documents. This supplement can be found at: http://hivlawandpolicy.org/resources/view/644

Human Immunodeficiency Virus (HIV) is the virus that leads to Acquired Immunodeficiency Syndrome (AIDS) in the absence of diagnosis and timely treatment. HIV attacks the immune system, which operates as the body's defense mechanism against infection. HIV finds and destroys the white blood cells (called T cells or CD4 cells) that bodies need to fight off disease. There are two important tests used to measure the progress of HIV disease in the body, one measures the number of CD4 cells present in a blood sample, and the other measures viral load (the amount of HIV in the blood). Since HIV attacks CD4 cells, people with HIV often see their CD4 counts drop as the disease progresses. The lower a CD4 count, the greater the chances of getting a number of very serious diseases.

Viral load tests measure the amount of HIV in the blood, and offer information about how quickly HIV is likely to damage the immune system. People with a high viral load are likely to get sick or die sooner than people with a low viral load. It has also become clear with recent research that people with lower viral loads are significantly less infectious then those with higher viral loads. HIV can progress to AIDS if one of two things occur. Either the CD4 cell count drops below 200 (600 or higher is within the normal range for an HIV-negative adult) or a person has HIV and develops one or more so-called "opportunistic" infections (e.g., pneumocystis carinii pneumonia (PCP), Kaposi's sarcoma, tuberculosis (TB)).

The innovation in the 1990's of antiretroviral therapy (ART), and especially highly active antiretroviral therapy (HAART), which involves a combination of three drugs from at least two classes of anti-HIV drugs, has helped many HIV-positive people avoid progressing to an AIDS diagnosis, and has helped people previously diagnosed with AIDS regain a higher CD4 cell count by suppressing their viral load.

Where earlier attempts at HIV treatment were ineffective, and in many cases only temporarily delayed death, HAART has restored opportunities for people with HIV to live long and full lives (see *HIV as a Chronic Condition* section for more details). The success of HAART is not universal however: some of the medications can cause debilitating side-effects that some individuals cannot tolerate, and a combination of complicated dosing regimes and/or side-effects can lead to missed doses and drug resistance. Additionally, some people without health insurance are unable to access treatment through federally-funded state programs due to long wait lists and underfunding.

Still, HAART has dramatically changed the landscape of HIV in the United States, where proper and consistent treatment can transform HIV to a chronic condition and reduce viral loads to often-undetectable levels.

"Transmission" is a term used to talk about how HIV is passed from one person to another. The most common modes of transmission are sexual contact and shared needles. The Centers for Disease Control and Prevention (CDC) has stated unequivocally that HIV cannot be transmitted through casual contact[1], which includes contact with saliva or oral/nasal mucus. Public health officials have worked hard to debunk myths and bad or incomplete science about how HIV can be transmitted. However, many criminal statutes regarding HIV continue to define "bodily fluids" in a way that includes spitting and other activities that cannot transmit HIV, and serve to reinforce myths about toxicity and transmission.

"Seroconversion" and "Serostatus" are terms often used in the discussion of HIV transmission. Seroconversion is a way to describe a change in HIV status (as measured by HIV antibody tests) from being HIV-negative to HIV-positive. Serostatus describes whether someone is HIV-positive or negative. These terms are often used when discussing transmission rates in scientific studies. Much less frequently used is the term "Seroreversion", which only applies to infants going from HIV-positive to HIV-negative as they develop their own immune system separate from their HIV-positive mother's.

Very few, if any, of the developments regarding HIV treatment and transmission have been addressed at law. In *Campbell v. State*, 2009 WL 2025344 (Tex. App. 2009)[2] an HIV-positive

[1] *HIV and Its Transmission*, Centers for Disease Control and Prevention (1999). Available at: http://hivlawandpolicy.org/resources/view/360.

[2] Available at: http://www.hivlawandpolicy.org/resources/view/529.

man's conviction for assault with a deadly weapon was affirmed by the Court of Appeals of Texas, after he allegedly became confrontational during an arrest and spat on a police officer's eyes and mouth. Campbell's appeal presented the court with an opportunity to revisit whether or not the saliva of an HIV-positive person could be considered a "deadly weapon." In 1992, the same court upheld the conviction of an HIV-positive man for attempted murder when he spit on a prison guard, allegedly believing that his saliva could kill the guard.[3] Unfortunately, in both cases the state medical witness testified, in the absence of any scientific evidence, that there was a theoretical possibility of HIV transmission through saliva, and the convictions were upheld. Campbell was sentenced to 35 years in prison.

Lawyers need to understand the changes in HIV treatment and the variations in transmission risks in order to provide zealous representation of their clients- who are often faced with unyielding stigma as well as criminal charges. HIV cannot continue to be treated as a deadly weapon in the courtroom, despite thirty years of development of treatment, reduction of viral loads, and increased understanding of how the virus is transmitted. Parlaying the science and research into understandable legal reasoning is a challenge, but one that must be met.

[3] Weeks v. State, 834 S.W.2d 559 (Tex. Ct. App. 1992).

II. HIV AS A CHRONIC CONDITION

Much of the law and policy related to HIV still relies on the outdated view of HIV as a death sentence. In a precedent reliant legal system, it can be a challenge to argue successfully against standards set in the 1980's and 1990's, even though they inaccurately portray today's science and understanding of HIV where treatment is available.

The following resources are meant to help craft and support legal arguments about HIV infection as a chronic, treatable condition such as diabetes, rather then as a death sentence. This is particularly helpful in cases where a client is charged with "assault with a deadly weapon" or "attempted murder," but can be used in all HIV criminalization cases, as well as civil cases such as child custody and visitation disputes.

The development of antiretroviral therapy and its impact on the HIV-1 AIDS pandemic, Samuel Broder, M.D., Antiviral Research (2010). Available: http://hivlawandpolicy.org/resources/view/590

This article explores the history of antiretroviral therapy development and the impact the therapy has had on the HIV/AIDS pandemic. It examines the issues this disease posed to the scientific community, specifically the limitations clinical researchers imposed on themselves due to the belief the retroviruses were not amenable to therapy. Despite the long-held belief that retroviruses are untreatable, researchers and clinical experts quickly identified antiretroviral agents that could be used to develop therapies that effectively treat patients with HIV/AIDS. In addition to the scientific and clinical innovations, the author highlights the important contributions of the FDA and pharmaceutical industries in the rapid development and distribution of antiretoriviral therapies for the treatment of HIV disease. This article also discusses the decrease in morbidity and mortality rates due to HIV/AIDS as a result of the distribution and utilization of antiretroviral medications.

As the author cites from the CDC's analysis, "advances in the treatment of HIV infection have resulted in a fundamental shift in its epidemiology, to a potentially chronic and manageable condition." The introduction of effective antiretroviral therapy has changed the perception of AIDS as an automatic death sentence to a condition that is treatable, and the availability of a therapy has reduced the marginalization and oppression of people living with HIV/AIDS. In addition to highlighting the advances and accomplishments since the advent of antiretrovirals, the article discusses areas for improvement and calls upon the research and clinical community to continue to work on improving the distribution of effective treatment and refining therapies that will permanently move this condition from a categorization as a life threatening disease to a chronic and manageable condition for people both in resource-rich and resource-poor countries.

- Useful quotation: "Antiretroviral therapy has brought about a substantial decrease in the death rate due to HIV-1 infection, changing it from a rapidly lethal disease into a chronic manageable condition, compatible with very long survival."

Scientific research on the risk of the sexual transmission of HIV infection and on HIV as a chronic manageable infection, D. McLay, E. Mykhalovskiy, & G. Betteridge, in E. Mykhalovskiy, G. Betteridge, & D. McLay, HIV Non-Disclosure and the Criminal Law:

Establishing Policy Options for Ontario (2010). Available at: http://hivlawandpolicy.org/resources/view/535

This document is a chapter excerpted from a larger policy report on the criminalization of HIV non-disclosure in Ontario, Canada. Although it is part of a Canadian report on recommendations for changes in Canadian law and practice, this section relies on the most current scientific research, including that by U.S.-based scientists, with findings on (1) the risks of transmission of HIV during sex; and (2) HIV as a manageable chronic disease. It outlines the conditions required for transmission of HIV from one person to another, reviews research on the risks of unprotected sexual activities including vaginal and anal intercourse and oral sex, addresses factors that increase or decrease the risk of sexual transmission of HIV, particularly recent research on ART and viral load, and briefly discusses HIV as a chronic manageable disease, including evolving data on death rates and life expectancies as a consequence of HIV treatment developments over recent years.

This type of information is extremely useful, if not essential, for various forms of advocacy against the use of criminal penalties against people with HIV for alleged failure to disclose their status to partners, from legal defense of those charged with a crime to public education. Many criminal laws and instances of prosecutions appear to hinge, at least in part, on gross ignorance of the modes and actual statistical risks of HIV transmission.

- Useful quotation: "The World Health Organization and other leading health authorities consider that, with proper medical care, HIV is a chronic manageable condition, similar in many ways to other chronic conditions such as diabetes or cardiovascular disease."

In Brief: Meeting the Sexual and Reproductive Health Needs of People Living with HIV, Guttmacher Institute & The Joint United Nations Programme on HIV/AIDS (2006). Available at: http://www.hivlawandpolicy.org/resources/view/295

The Guttmacher Institute outlines the changing sexual and reproductive health needs of people living with HIV as the disease has become a manageable chronic disease. Included is information on fertility issues and childbearing, prevention of unplanned pregnancy, and effective transmission prevention for discordant couples. The article also addresses common issues of discrimination and bias in medical and other settings, such as disclosure of HIV status without consent, coerced abortion and sterilization, and unwillingness to accept the sexuality of HIV-positive people, which affect access to adequate sexual and reproductive health care. This article may be particularly useful to medical providers serving HIV-positive people, and to advocates seeking an understanding of common issues facing people living with HIV with regard to reproductive health.

- Useful quotation: “For those with access to treatment services, a diagnosis of HIV infection is no longer an imminent death sentence; although still incurable, HIV now can be managed as a chronic disease.”

Centers for Disease Control and Prevention’s general treatment information for HIV. Available at: http://www.cdc.gov/hiv/topics/treatment/index.htm

This website includes information about the CDC’s current guidelines for treatment, as well as other information and fact sheets.

- Useful quotation: "Although there is no cure for HIV infection, there are treatment options that can help people living with HIV experience long and productive lives."

Guide to Primary Care for People with HIV/AIDS, Department of Health and Human Services, Health Resources and Services Administration. Available at: http://www.hab.hrsa.gov/tools/primarycareguide/index.htm

This government guide for medical practitioners includes the section "Primary Care as Chronic Care." While this document is primarily for medical use, it can be useful to establish the widespread, and cross-disciplinary, standards that treat HIV as a chronic and manageable condition.

- Useful quotation: "HIV is now a chronic disease requiring ongoing primary care management."

III. HIV AS A COVERED DISABILITY UNDER THE ADAAA

In September 2008, the Americans with Disabilities Act Amendments Act (or ADAAA) was signed into law, with implementing regulations released in March 2011. The ADAAA makes important changes to the definition of the term "disability" by rejecting the holdings in several Supreme Court decisions and portions of the EEOC's Americans with Disabilities Act (ADA) regulations. The effect of these changes is to make it easier for an individual with HIV seeking protection under the ADA to establish that he or she has a disability within the meaning of the ADA.

The ADAAA specifically includes impact on the immune system as a major life activity, an inclusion that, if framed and referenced properly, can be the basis for HIV as a covered disability under the ADAAA. These arguments will be newly made in court, and counsel should be prepared to articulate how HIV is an immune disorder, and therefore a covered disability. Though this is unlikely to come up in criminal cases, and can in fact seem to be in tension with section II above, establishing HIV as a disability is a necessary tool in any number of other cases, and the new focus on the immune system makes sample scientific language invaluable.

This section begins with paragraphs that can be used in an expert affidavit in cases where the attorney is establishing that the HIV-positive client is a person with a disability under the ADAAA. This is followed by a few persuasive sources with selected language regarding the effect of HIV on the immune system. While this section is not exhaustive, it does provide good preliminary authorities.

Sample Paragraphs, Center for HIV Law and Policy (2011).

HIV disease is a continuous, progressive process beginning with primary infection, continuing in most cases through an extended chronic stage typically without visible symptoms, and eventually leading to significant deterioration of the immune system ("immunodeficiency") and the onset of opportunistic infections. At every stage of HIV

infection, the virus attacks the immune system and weakens it. It is a medical fact that untreated HIV infection substantially limits the function of the immune system. [4]

The disruption of immune responses opens the way to infection by a range of different microorganisms that can be severely disabling and fatal. For example, the immune deficiency that results from HIV infection also results in a susceptibility to several types of cancer. Regardless of whether individuals are at the early, middle or advanced stages of HIV disease, each stage is an aspect of the same chronic, progressive disease, the hallmark of which is a compromised immune system.[5]

Fast Facts About HIV, UNAIDS (2008). Available at: http://www.unaids.org/en/resources/presscentre/fastfactsabouthiv/

"HIV is a virus (of the type called retrovirus) that infects cells of the human immune system (mainly CD4 positive T cells and macrophages—key components of the cellular immune system), and destroys or impairs their function. Infection with this virus results in the progressive deterioration of the immune system, leading to 'immune deficiency'.

The immune system is considered deficient when it can no longer fulfill its role of fighting off infections and diseases. Immunodeficient people are more susceptible to a wide range of infections, most of which are rare among people without immune deficiency. Infections associated with severe immunodeficiency are known as 'opportunistic infections', because they take advantage of a weakened immune system."

What is AIDS? NY State HIV/AIDS Information Service (2007). Available at: http://www.nyaidsline.org/app/index.php?pid=2

"HIV is a retrovirus that infects several types of cells in our body, most importantly the CD4+ T Lymphocyte. The CD4+ T-cell is a white blood cell that is a major component of the human immune system that helps fight infection/disease and some types of cancer. By killing CD4+ T-cells, HIV progressively destroys the body's ability to fight infection. HIV is the causative agent for AIDS (Acquired Immunodeficiency Syndrome)."

HIV and Its Treatment: What You Should Know, National Institutes of Health (2009). Available at: http://www.aidsinfo.nih.gov/other/FactSheetDetail.aspx?ClassID=111

"Your immune system is your body's defense system. Cells of your immune system fight off infection and other diseases. If your immune system does not work well, you are at risk of serious and life-threatening infections and cancers. HIV attacks and destroys the disease-fighting cells of the immune system, leaving the body with a weakened defense against infections and cancer."

[4] *See*, *e.g.*, Centers for Disease Control & Prevention ("CDC"), *Basic Information*, ("CDC, Basic Information").
[5] Anthony S. Fauci, *Multifactorial Nature of Human Immunodeficiency Virus Disease: Implications for Therapy*, 262 Science 1011 (1993). P.R. Dohen and P.A. Volberding, CLINICAL SPECTRUM OF HIV DISEASE, THE AIDS KNOWLEDGE BASE 4.1-4 (P.T.Cohen et al. eds., 2nd ed. 1994). See also, e.g., J.E. Gallant et al. eds., HIV GUIDE, http://hopkins-hivtguide.org

IV. HIV TRANSMISSION ROUTES AND RELATIVE RISKS

HIV transmission is often treated, in law and in conversation, as a certainty if an individual is exposed to the virus. It can be challenging to accurately address the relative transmission risks of behaviors while HIV-positive without appearing to minimize the seriousness of the virus or undermine public health efforts. However, as passionate advocates for our clients, it is necessary.

One of the bedrocks of HIV criminalization is the false assumption that all exposures to HIV present equal risks of transmission. This is a significant departure from the standards of intent and risk that are otherwise found in common and statutory law. The following resources provide data about actual transmission risks and rates, and demonstrate the considerable variation in risk among different exposures. While exposure to saliva is criminalized in many states, the CDC has stated that HIV cannot be transmitted through spitting. And while many statutes refer to "sexual contact", there is a huge, well-documented difference in risk of transmission from oral sex, to receptive vaginal intercourse, to protected insertive anal sex, and all the variations in between. As the articles below illustrate, oral sex (which in this context is almost always fellatio, not cunnilingus), has a much lower transmission risk than other sorts of sexual contact, and the variables regarding the risks of all vaginal, anal and oral sex depend on whether the person with HIV is insertive (higher risk of transmission) rather than receptive (lower risk). Statutes and courts also fail to consider the use of condoms in criminal prosecutions for HIV exposure, despite all the scientific and public health support for their use, and their significant reduction in transmission risk. Because courts rarely, if ever, consider what role actual statistical risk should have in HIV exposure prosecutions, it is an important issue to raise.

HIV and Its Transmission, Centers for Disease Control and Prevention (1999). Available at: http://hivlawandpolicy.org/resources/view/360

This fact sheet from the Centers for Disease Control and Prevention (CDC) outlines the ways in which HIV can and cannot be transmitted from one individual to another. HIV is primarily transmitted through sexual contact, by sharing needles and/or syringes, or from mother to child before or during birth or during breastfeeding. The document dispels myths about transmission through the environment, households, businesses, kissing, biting, saliva, sweat, tears, and insects. It addresses the very small number of known cases of transmission from patients to health care providers through needle sticks (or, more rarely, through blood getting into a health care worker's exposed mucous membrane), and that there is only one known instance in which a health care provider transmitted HIV to patients. It should be noted that this is a conservative document, by an agency that resists making declarative statements about risk because of improbable, but scientifically possible, scenarios. Despite that, the document emphasizes the limited routes of transmission that have been identified, and states that condoms are highly effective in preventing the spread of HIV through sexual contact.

- Useful quotations:
  - "Contact with saliva, tears, or sweat has never been shown to result in transmission of HIV."

- "Numerous studies among sexually active people have demonstrated that a properly used latex condom provides a high degree of protection against a variety of sexually transmitted diseases, including HIV infection."

Quantifying sexual exposure to HIV within an HIV-serodiscordant relationship: development of an algorithm, Julie Fox et al., AIDS (2011). Available at: http://hivlawandpolicy.org/resources/view/621

The risk of acquiring HIV from a single sexual contact varies enormously, reflecting biological and behavioral characteristics of both infected and uninfected partners. This article systematically reviewed current literature on HIV transmission estimates, and developed an HIV risk score that would allow quantification of overall risk of HIV acquisition within HIV-serodiscordant partnerships. The HIV risk score enumerates the relative risk of HIV acquisition from HIV-positive partners incorporating the type and frequency of specific sex acts, the HIV plasma viral load and stage of disease, the presence of genital ulcer disease in either partner, and pregnancy, HSV-2 seropositivity, and circumcision status (men only) in the HIV-negative partner.

The authors conclude that key determinants of HIV exposure risk can be incorporated into a mathematical model in order to quantify individual relative risks of acquiring HIV. They intend for the model to facilitate comparisons within clinical trials of exposed, uninfected individuals and facilitate interventions to reduce HIV transmission. In addition to providing valuable, though dense, data on the comparable risks of sexual HIV transmission, the article also gives a sense of the sheer volume of factors that influence transmission.

- Useful quotations:
  - "The risk of HIV transmission reflects two distinct entities, the relative risk of HIV acquisition amongst HIV-uninfected individuals, which represents a composite of genetic factors, immunological factors, nature and frequency of sexual exposure, and presence of concurrent sexually transmitted infections (STIs) and the onward transmission risk posed by HIV-infected individuals which is determined by HIV plasma and genital tract viral load, concomitant STIs, viral characteristics."
  - "Mathematical models suggest that although the risk of transmission on effective suppressive ART is not zero it is very low."

Heterosexual risk of HIV-1 infection per sexual-act: systematic review and meta-analysis of observational studies, Boily et al., Lancet (2009). Available at: http://hivlawandpolicy.org/resources/view/578

This article follows up on an earlier study by the same authors examining per-act heterosexual HIV transmission probabilities. It is a systematic review and analysis of all available study data related to the likelihood of heterosexual HIV transmission. The authors reviewed 43 published studies conducted in various countries that reported per-act heterosexual HIV-1 transmission probability estimates. The authors concluded that the average male to female risk of HIV transmission is .07 - .08% per vaginal sex act (which, in a large study, would mean approximately 7-8 cases of transmission for every 10,000 acts of unprotected vaginal sex) if there was no receptive anal intercourse, the HIV-positive person

was asymptomatic, and there were no other cofactors present, such as other sexually transmitted infections.

The authors' three objectives were to provide summary estimates of HIV-1 transmission probabilities per heterosexual contact; do in-depth single variable and multivariable analysis to explore the reasons for different study results; and estimate the role of risk factors such as viral load and STIs on the likelihood of transmission.

The authors point out that putting a number on the actual likelihood of HIV transmission in a single sexual act is difficult to measure. The actual transmission to a partner, the number of unprotected sex acts, the length of the partner's exposure to HIV, and other potential co-factors among the people who participate in a study about their sex acts are rarely completely known and there are unreported factors, such as some participants actually having other STIs, which could affect the accuracy of studies. Of course, this is likely true of most, if not all, studies that attempt to base conclusions on what people report about their sex lives.

Important findings include that, overall, female-to-male (.04% per act or, in theory, about 4 cases of HIV transmission per every 10,000 acts of vaginal sex with a woman who is HIV-positive) and male-to-female (.08% per act or 8 cases of HIV transmission per every 10,000 acts of vaginal sex with a man who is HIV-positive) transmission estimates in high-income countries show a low risk of infection even when the person with HIV is not on antiretroviral treatments.

Other findings showed that there were higher estimates of HIV transmission during receptive anal sex (1.7% per act or 17 cases of HIV transmission per every 1,000 acts of anal sex in which the "top" is HIV-positive) as opposed to other sexual acts. There also were larger estimated risks of HIV transmission for sexual acts during the early (9.2 to times greater) and late phases (7.3 times greater) of a partner's HIV infection than for sexual acts during the asymptomatic phase of HIV disease. Finally, the authors state that commercial sex exposure and/or genital ulcers in either sexual party increased per-act risk of infection 5.3 times in comparison to the same acts in which sex partners did not have an STI.

- Useful quotation: "Pooled female-to- male (0.04% per act [95% CI 0.01–0.14]) and male-to-female (0.08% per act [95% CI 0.06–0.11]) transmission estimates in high-income countries indicated a low risk of infection in the absence of antiretrovirals."

Per-Contact Risk of Human Immunodeficiency Virus Transmission Between Male Sexual Partners, Eric Vittinghoff et al., 150 AM. J. EPIDEMIOLOGY 306 (1999). Available at: http://hivlawandpolicy.org/resources/view/599

This study of 2,169 homosexual and bisexual men sought to find the rates of seroconversion during various sexual acts—both protected and unprotected—per sexual contact. Out of the entire group, 60 seroconversions occurred over the two-year period between 1992-1994. While the study affirms, unsurprisingly, that unprotected receptive anal sex with a knowingly HIV-positive partner carries the highest risk of per-contact infection, the same sex acts with a partner of an unknown serostatus carry a per-contact risk similar to that of needle-stick injuries, and occurred in this study about one-third to one-half as frequently as unprotected receptive anal sex. Also not surprisingly, protection, such as condoms, significantly lowers the risk of infection in both cases.

Other sex acts, such as unprotected receptive oral sex and unprotected insertive anal sex carry an even lower, though still existent, HIV seroconversion risk. The per-contact risk associated with unprotected insertive anal and receptive oral sex with HIV-positive or unknown serostatus partners was 0.06 and 0.04 percent, respectively.

The authors note, however, that individual risk varies on the basis of factors such as viral load, and that about 15 percent of infections occurred after only one or two sexual contacts. Individuals who engaged in unprotected receptive anal intercourse with a partner who was knowingly HIV-positive -- and who consequently were at the highest per contact risk of HIV transmission -- still seroconverted at a rate of only 0.82% per contact, or less than once in 100 acts of unprotected, receptive anal sex.

The authors maintain that the fact of transmission between partners in situations where HIV serostatus is unknown suggests that interventions like post-exposure prophylaxis should not be withheld from individuals who engage in unprotected receptive anal intercourse with a partner of an unknown serostatus, since the risk of transmission is similar to that following needlestick accident involving a HIV-positive individual, for which current guidelines recommend PEP.

- Useful quotation: "The estimated per-contact risk of acquiring HIV from unprotected receptive anal intercourse (URA) was 0.82 percent (95% confidence interval: 0.24, 2.76 percent) when the partner was known to be HIV+ and 0.27 percent (95% confidence interval: 0.06, 0.49 percent) when partners of unknown serostatus were included."

Systematic Review of Orogenital HIV-1 Transmission Probabilities, R. F. Baggaley, R. G. White, and M. Boily, 37 INT'L J. OF EPIDEMIOLOGY 1255-1265 (2008). Available at: http://ije.oxfordjournals.org/content/37/6/1255.full

Believing that it is important to have a better understanding of the actual risks of HIV transmission through oral sex, the authors reviewed and summarized all available research literature, up to July 2007, on the risk of HIV transmission associated with oral sex between men, between women, and between men and women. The authors concluded that the available research was inadequate to determine the actual risk associated with oral sex. Because the risk of transmission is clearly very low, much larger studies would be required to assign a more precise statistical risk factor to oral sex. As the authors note, in cases where oral sex is reported as the only sexual conduct in which an interview was active, there is certainly the possibility of social desirability bias or other reasons why a higher risk interaction, particularly anal intercourse, might not be recalled. The takeaway: the risk of HIV transmission via oral sex is extremely low but greater than zero.

- Useful quotations:
  - "Although transmission risk per-act or per-partner through any type of OI [oral intercourse] activity remains poorly quantified…our review suggests a low but non-zero transmission probability."
  - "The fact that infected study participants with solely this exposure have remained difficult to identify may suggest that indeed the contribution of OI to HIV incidence remains low."

Condom Effectiveness in Reducing Heterosexual HIV Transmission (Review), Weller & Davis-Beaty, The Cochrane Library (2007). Available at: http://apps.who.int/rhl/reviews/CD003255.pdf

This is a large-scale review of the data and conclusions of numerous cohort studies about condom effectiveness in reducing heterosexual HIV transmission. After reviewing and critiquing substantial data, the authors conclude that "Using condoms consistently reduces sexual transmission of HIV infection" and that "Sexual intercourse and contact with contaminated blood products (e.g., intravenous drug use) account for the majority of HIV infections. The use of condoms during sexual intercourse has been promoted to reduce the infection and spread of sexually transmitted infections (STIs) such as HIV."

- Useful quotations:
  - "The review of studies found that condoms, when used consistently, substantially reduced HIV infection but did not totally eliminate the risk of infection."
  - "This review indicates that consistent use of condoms results in 80% reduction in HIV incidence. Consistent use is defined as using a condom for all acts of penetrative vaginal intercourse. Because the studies used in this review did not report on the "correctness" of use, namely whether condoms were used correctly and perfectly for each and every act of intercourse, nor did they report on the quality of the condoms used, effectiveness and not efficacy is estimated."

Effectiveness of Condoms in Preventing HIV Transmission, S.D. Pinkerton, P.R. Abranson, 44 SOC SCI MED. 1303 (1997).

This study argues for the effectiveness of condoms in HIV prevention by looking at the existing quantitative evidence. Although meta-analyses of condom effectiveness at the time of this article suggested that condoms are 60 to 70% effective when used for HIV prophylaxis, these studies did not isolate consistent condom use, and therefore provided only a lower boundary on the true effectiveness of correct and consistent condom use. The reexamination of HIV seroconversion studies in this article suggests that condoms are 90 to 95% effective when used consistently, i.e. consistent condom users are 10 to 20 times less likely to become infected when exposed to the virus than are inconsistent or non-users. Similar results were obtained utilizing model-based estimation techniques, which indicate that condoms decrease the per-contact probability of male-to-female transmission of HIV by about 95%. The authors conclude that though imperfect, condoms provide substantial protection against HIV infection.

- Useful quotation: "A reexamination of HIV seroconversion studies suggests that condoms are 90 to 95% effective when used consistently, i.e. consistent condom users are 10 to 20 times less likely to become infected when exposed to the virus than are inconsistent or non-users."

Rapid Review: Effectiveness of female condoms for preventing HIV/AIDS and factors that impact uptake, OHTN Rapid Response Service, Ontario HIV Treatment Network (2010). Available at: http://www.ohtn.on.ca/Documents/Knowledge-Exchange/Rapid-Review_12_FemaleCondom_2009.pdf

This is a briefing paper that reviews the current science and considerations related to female condom use for HIV prevention. The authors conclude that 1) female condoms are effective in preventing the transmission of HIV/ AIDS; 2) female condoms are important for improving female control and confidence in the negotiation and practice of safe sex; 3) there is much discrepancy around the sociodemographic factors that make women more likely to use female condoms; and 4) interventions that focus on improving attitudes towards female condoms, through increased communication and education of both partners, increase their use.

- Useful quotation: "Considerable evidence exists to suggest that the female condom is effective both in increasing protected sex acts and possibly in reducing STI incidence. However, much more research is needed to support these conclusions, especially with respect to rural and community settings."

Condoms and STDs: Fact Sheet for Public Health Personnel, Centers for Disease Control and Prevention. Available at: http://www.cdc.gov/condomeffectiveness/latex.htm

This fact sheet presents evidence concerning the male latex condom and the prevention of STDs, including HIV, based on information about how different STDs are transmitted, the physical properties of condoms, the anatomic coverage or protection that condoms provide, and epidemiologic studies assessing condom use and STD risk. This fact sheet updates previous CDC fact sheets on male condom effectiveness for STD prevention by incorporating additional evidence-based findings from published epidemiologic studies. It also includes a bibliography of many recent studies and articles.

- Useful quotation: "Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS."

Investigation of Patients Treated by an HIV-Infected Cardiothoracic Surgeon—Israel, 2007, 57 MMWR 1413 (2009). Available at: http://hivlawandpolicy.org/resources/view/347

Acknowledging that the threat posed by HIV-positive health care providers, including surgeons, to their patients is negligible, the CDC discusses an investigation tracking the patients of an HIV-positive cardiothoracic surgeon in Israel. Cardiothoracic surgery is among the most invasive medical interventions, which is why Israeli officials were concerned when this surgeon, who had been practicing for more than 10 years and had treated more than 1600 patients, tested positive for HIV. In response, officials conducted an investigation of patients treated by the surgeon in the 10 years prior to his diagnosis and determined that none had tested positive for HIV. They were able to confirm this with near certainty by comparing the list of patients with the national HIV registry, on which all diagnosed individuals with HIV must be listed. After determining that the surgeon did not pose a threat to his patients, the surgeon was cleared to continue with his practice, with no need to notify patients of his HIV status, as long as he continued to abide by established infection control protocols.

In the editorial following the report, the CDC stated that "the data in this and other studies published since the CDC guidelines of 1991, considered together, argue for a very low risk for provider-to-patient HIV transmission in the present era and could form the basis for national and international public health bodies to consider issuing revised guidelines for

medical institutions faced with HIV infection in a health-care worker performing exposure-prone procedures." This statement reconfirms the very low risk of surgeon-to-patient HIV transmission, even in procedures the CDC characterizes as "exposure-prone." More significantly, it suggests that it is time for medical institutions – and perhaps the CDC itself – to consider revising guidelines that allow the exclusion or practice-restriction of HIV-positive health care workers on the basis of HIV status. This article would be useful in employment cases in which termination, exclusion or job-reassignment is at issue based on perceptions of HIV contagiousness or a belief that an employee poses a "direct threat" to others in the work place, particularly in healthcare settings.

- Useful quotations:
  - "[T]he data in this and other studies published since the CDC guidelines of 1991, considered together, argue for a very low risk for provider-to-patient HIV transmission in the present era and could form the basis for national and international public health bodies to consider issuing revised guidelines for medical institutions faced with HIV infection in a health-care worker performing exposure-prone procedures."
  - "The results of this investigation add to previously published data indicating a low risk for provider-to-patient HIV transmission."

HIV Transmission: Can HIV be transmitted through a human bite?, Ctr. for Disease Control & Prevention, (March 25, 2010). Available at: http://www.cdc.gov/hiv/resources/qa/transmission.htm

This is a basic reference for transmission risks that uses extremely accessible language. The CDC presents conservative advice and data, but it is important to know about this study and the cautious language with which the CDC describes the risk of transmission via biting.

- Useful quotation: "Biting is not a common way of transmitting HIV, in fact, there are numerous reports of bites that did not result in HIV infection. Severe trauma with extensive tissue damage and the presence of blood were reported in each of the instances where transmission was documented or suspected. Bites that do not involve broken skin have no risk for HIV transmission, as intact skin acts as a barrier to HIV transmission."

HIV Transmission: Can HIV be transmitted by being spit on by an HIV infected person?, Ctr. for Disease Control & Prevention, (March 25, 2010). Available at: http://www.cdc.gov/hiv/resources/qa/transmission.htm

This a basic reference for transmission risks that uses extremely accessible language. The CDC presents conservative advice and data, but it can be a useful starting citation.

- Useful quotation: "Can HIV be transmitted by being spit on?" "No. In some persons living with HIV, the virus has been detected in saliva, but in extremely low quantities. Contact with saliva alone has never been shown to result in transmission of HIV, and there is no documented case of transmission from an HIV-infected person spitting on another person."

Lack of Transmission of HIV Through Human Bites and Scratches, Chris M. Tsoukus et al., 1 J.A.I.D.S. 505 (1988). Available at: http://hivlawandpolicy.org/resources/view/576

This limited study, conducted during the mid-1980's, chronicles the lack of transmission of HIV through bites and scratches. The study followed only one patient, an HIV- positive hemophiliac with severe brain damage, who was incontinent, masturbated frequently, had poor dental hygiene that led to extreme bleeding in his gums, and often had untrimmed nails. He was violent and hostile toward the hospital staff; out of 198 medical workers who provided care for him, he bit and/or scratched 30 of them. This is the entire basis of the study.

Although his viral load was high, after 2.5 years of consistent follow-up, all of the traumatized medical workers remained HIV-negative. The authors concluded that, "The risk of transmission of HIV through this route under similar conditions should be low." Their conclusion has been supported by the ensuing twenty-two years of research.

- Useful quotation: "Bites and scratches from the patient described in this paper should have constituted a high risk of HIV transmission through skin trauma because of the frequent presence of blood, pus, and copious amounts of saliva in his mouth as well as the presence of semen, blood, and fecal matter coating his fingernails. Despite these risks we did not find any evidence of acquired immune dysfunction or transmission of HIV to those health care workers who were scratched, cut, or bitten by this HIV carrier."

HIV and Pregnancy: Medical and Legal Considerations for Women and Their Advocates, Center for HIV Law and Policy, (2009). Available at: http://hivlawandpolicy.org/resources/view/474

Mother to child transmission of HIV raises specific medical issues and legal concerns. This report and guide outlines these medical and legal issues surrounding HIV and pregnancy in the United States. It makes it clear that persistent beliefs among medical, social service, and justice system professionals that women with HIV should avoid childbearing are unsupported by medical science or the law. The guide is the first of its kind, and charts the intersecting medical, ethical, and legal issues that can arise for HIV-positive women who are or may become pregnant. It underscores not only the legal basis, but the public health advantage, of treating women as active partners in their own and their newborns' treatment, and recognizing their right to appropriate counseling and medical care that accommodates their reproductive options. The guide provides a frank, balanced discussion of the medical issues and options women will encounter at all stages of their pregnancy, and how to deal with legal issues that also may arise when their right to make choices are challenged.

This resource will be useful in situations or cases in which the risks and rates of transmission from mother to child are in play. While the use of antiretrovirals, coupled with interventions such as delivering via caesarean surgery can dramatically reduce the risks of HIV transmission from mother to child, there are other serious health and human rights concerns that should be considered. Understanding the transmission rates and risks, as well as the possible interventions, is the right of every HIV-positive pregnant woman. Other resources on transmission rates cited within the manual include Patricia M. Garcia et al., *Maternal Levels of Plasma Human Immunodeficiency Virus Type 1 RNA and the Risk of Perinatal Transmission*, 341 NEW ENG. J. MED. 394 (1999).

- Useful quotation: "Although the risk of an HIV-positive mother transmitting the virus to her fetus or newborn is only 25% without any intervention, the risk may be reduced to as low as 2% if the mother follows certain protocols, including the use of anti-HIV medications during pregnancy and childbirth. Whether following these protocols is appropriate, however, will depend on the woman's individual medical circumstances."

Sample Expert Statement on HIV Transmission Risk, Center for HIV Law & Policy. Available at: http://hivlawandpolicy.org/resources/view/381

To avoid a court battle, or to win a case once in court, people with HIV may need to introduce evidence or affidavits demonstrating that they pose no significant risk of transmitting HIV to others through casual contact. In these cases, it can be extremely important to have the assistance of a medical or scientific expert, usually an infectious disease physician, to provide testimony or an affidavit about the relative risks of HIV transmission. The goal in these cases is to educate and persuade a potential adversary, or the trier of fact, whether a judge or a jury, that the HIV-positive person poses no threat of transmission through casual contact, or if the context is consensual sex, no significant risk of transmission when, for example, viral load is undetectable and/or a condom is used. In short, the expert provides the back-up for the argument that HIV infection alone is not an appropriate basis for, e.g., changes in child custody orders, criminal convictions, or exclusion from a workplace. This sample expert statement, which describes the various ways in which HIV is and is not transmitted, may be adapted to meet the needs of specific situations.

V. VIRAL LOAD AND TREATMENT

Unaddressed in most criminal cases related to HIV exposure is the extent to which viral load, often affected by treatment, influences transmissibility. Multiple studies have shown that a low viral load dramatically decreases the transmission risk - less virus in the body = less virus to transmit. But the significant reduction in transmission risk for individuals with low viral load (which is often, but not always, caused by consistent use of highly active antiretroviral therapy (HAART)) is absolutely relevant in defending criminal cases, and the following studies and articles can provide important scientific support.

One word of caution: advocates should construct low-risk of harm defenses around the already-low average risk of transmission even in the absence of treatment (<1% in the most risky type of sexual contact, i.e., unprotected receptive anal sex). Exclusive reliance on treatment-induced low viral load as a defense could effectively narrow the scope of potential defendants to an underclass of those with HIV who do not have effective treatment or who no longer respond to available therapies. Furthermore, it is the burden of the prosecution to prove harm or risk of harm, not the burden of the defendant to show a lack of risk. Using this strategically is beyond the scope of this document, but it is an important basis of argument for a criminal defense attorney to keep in mind.

Antiretroviral therapy for prevention of HIV transmission in HIV-discordant couples (Review), A. Anglemyer et al., COCHRANE DATABASE OF SYSTEMATIC REVIEWS (2011). Available at: http://hivlawandpolicy.org/resources/view/622

This article found seven observational studies that had examined whether antiretroviral drugs prevent transmission of HIV from an infected sexual partner to an uninfected one, and reviewed the results for conclusions. The authors found that in couples in which the infected partner was being treated with antiretroviral drugs the uninfected partners had more than 5-times lower risk of being infected than in couples where the infected partner was not receiving treatment. Since the World Health Organization already recommends antiretroviral treatment for all persons with ≤350 CD4 cells/μL, the authors also examined studies that had looked at partners with CD4 counts higher than this level.

While these reviewers found that there was inconclusive evidence that HIV was less likely to be transmitted in the higher CD4 count group, a large randomized trial was being conducted, and was concluded early in May 2011 because of it's outstanding results. The trial, conducted by the HIV Prevention Trials Network, was of serodiscordant couples where the person with HIV had a CD4 cell count of between 350 and 550 and were therefore not yet eligible for treatment for their own health according to WHO guidelines. The reduction of sexual transmission of HIV if an HIV-positive person adheres to an effective antiretroviral therapy regimen was so significant, at 96%, that the trial was stopped 3-4 years ahead of schedule. More information on this data should become available at http://www.hptn.org/.

- Useful quotation: "Overall we found that in couples in which the infected partner was being treated with antiretroviral drugs the uninfected partners had more than 5-times lower risk of being infected than in couples where the infected partner was not receiving treatment."

How Reliable is an Undetected Viral Load? C. Combescure et al., HIV MEDICINE (2009). Available at: http://hivlawandpolicy.org/resources/view/593

A study by the Swiss Federal AIDS Commission on patients who were treated with highly active antiretroviral therapy (HAART) concluded in 2009 that individuals with a stable, low viral load for at least six months were extremely unlikely to transmit HIV. In response, the Swiss HIV Cohort Study sought to determine how consistently viral load remains below detectable levels.

The study concludes that when several successive viral loads are less than 50 copies/mL it remains reliably undetectable approximately 94% of the time with a cut-off of 50 copies/mL, and approximately 99% reliable with a cut-off of 1000 copies/mL.

The most significant factor in maintaining a reliably undetectable viral load is consistent compliance with a patient's HAART regimen. Also affecting reliability was the patient's past drug therapy, i.e., the type of HAART and the first antiretroviral therapy the patient received. Patients who started with HAART had a higher rate of reliability than those who started on NRTI mono- or bi- therapy (the first class of antiretroviral drugs developed) in the 1990s.

- Useful quotations:
  - "The Swiss Federal AIDS Commission's review of data concerning the contagiousness of patients treated with highly active antiretroviral therapy (HAART) concluded that patients with stably suppressed viral load (VL) on treatment were extremely unlikely to pass on their infection."
  - "After several successive VLs at <50 copies/mL, reliability reaches

approximately 94% with a cut-off of 50 copies/mL, and approximately 99% with a cut-off at 1000 copies/mL."

Relation Between HIV Viral Load and Infectiousness: a Model-Based Analysis, David Wilson, et al., Lancet (2008). Available at: http://hivlawandpolicy.org/resources/view/510

A consensus statement released on behalf of the Swiss Federal Commission for HIV/AIDS suggests that people receiving effective antiretroviral therapy—i.e., those with undetectable plasma HIV RNA (<40 copies per mL)—are sexually non-infectious. The authors analysed the implications of this statement at a population level. The authors used a simple mathematical model to estimate the cumulative risk of HIV transmission from effectively treated HIV-infected patients (HIV RNA <10 copies per mL) over a prolonged period. They investigated the risk of unprotected sexual transmission per act and cumulatively over many exposures, within couples initially discordant for HIV status. The analyses suggest that the risk of HIV transmission in heterosexual partnerships in the presence of effective treatment is low but non-zero and that the transmission risk in male homosexual partnerships is high over repeated exposures. If the claim of non-infectiousness in effectively treated patients was widely accepted, and condom use subsequently declined, then there is the potential for substantial increases in HIV incidence.

- Useful quotation: "Although the primary purpose of antiretroviral therapy is to slow disease progression in people with HIV infection, it is likely to have the secondary benefit of reducing the risk of new transmission to HIV-negative sexual partners."

Viral Load and Heterosexual Transmission of Human Immunodeficiency Virus Type 1, Thomac C. Quinn, M.D. et al., 342 NEW ENG. J. MED. 921 (2001). Available at: http://hivlawandpolicy.org/resources/view/591

This study, which took place between 1994 and 1998 in Rakai, Uganda, tracked the HIV-1 transmission rate in 415 heterosexual couples with discordant HIV-1 status. Of the couples surveyed, 22% of the HIV-negative partners seroconverted during the course of the study. While age and circumcision status were significant factors in the risk of seroconversion, the study found that the infected partner's viral load was the factor most strongly predictive of the risk of transmission.

While most of the factors surveyed--such as history of sexually transmitted diseases, time outside the area, or number of sexual partners--were not predictive of risk, whether or not a male HIV-negative partner was circumcised was a significant factor in transmission. In HIV-1 negative males, there were no infections among 50 circumcised men. Among uncircumcised males, however, 40 out of 137 seroconverted in the course of the study.

HIV transmission between partners also increased if the HIV-positive partner had a history of genital discharge, painful urination, or AIDS defining symptoms. Age was also associated with infection risk in discordant partners, and risk decreased with age.

Viral load was, overall, the most significant transmission risk factor. Among couples where one partner was seronegative and later converted, their partners had, on average, a significantly higher viral load level than those who remained seronegative. Similarly, there were no transmissions in couples where the seropositive partner had an undetectable viral

load. The study did not, however, isolate the extent to which individuals with low viral loads were also on highly active antiretroviral therapy or other antiretroviral treatments. Other studies, such as the Swiss "How Reliable is the Undetectable Viral Load," also have shown that people who have an undetectable viral load and take HIV antiretroviral consistently are effectively noninfectious.

- Useful quotation: "The viral load is the chief predictor of the risk of heterosexual transmission of HIV-1, and transmission is rare among persons with levels of less than 1500 copies of HIV-1 RNA per milliliter."

VI. PHYLOGENETIC ANALYSIS

Phylogenetic analysis, in the context of criminal prosecutions for HIV transmission, means the analysis of the relatedness between two samples of HIV. Phylogenetic analysis comes up in criminal law cases, particularly in some European cases, as evidence of source of transmission. There are significant limitations to this type of analysis, even when done under rigorous forensic conditions. Most commonly cited is that there is no way to identify the direction of transmission (which is to say, while you can determine that two samples of HIV taken from two different people are closely related, you cannot prove who gave it to whom).

While understanding phylogenetic analysis can be important in planning all possible arguments and in reading existing case law, there are significant considerations before introducing it in a case. Many of these are expounded on in the articles below, but drawbacks include the seeming validation of the structure of the criminal charges, the not insignificant cost, and the difficulty of communicating the scientific limitations to the court.

The use of phylogenetic analysis as evidence in criminal investigation of HIV transmission, Edwin J. Bernard and Yusef Azad et al., HIV FORENSICS (2007). Available at: http://hivlawandpolicy.org/resources/view/610

This briefing paper is an introduction to complex scientific and social issues surrounding using scientific analysis of HIV strands in criminal prosecutions. This type of analysis is sometimes suggested as a way to support criminal convictions for HIV transmission, without reference to the scientific and public health limitations. Using plain language, the article addresses the "incorrect assumption that phylogenetic analysis can provide definitive evidence of the route, direction, and timing of HIV transmission. There are, in fact, many limitations regarding what this scientific evidence can 'prove'," and these are discussed in detail in the article.

Some examples of the limitations that should be addressed if using phylogenetic analysis in a trial are that it cannot by itself prove that transmission occurred between individuals and even if phylogenetic analysis suggests viral relatedness, it does not provide any information on the direction of that transmission.

The context of the article is the criminal justice system in England and Wales, but the information about, and significant limitations of, phylogenetic analysis have wide ranging applicability. As described in the introduction of the article: "This short briefing paper is aimed at professionals working in the criminal justice system and HIV professionals who may be called as expert witnesses in criminal HIV transmission cases. It may also be useful

for people working in HIV support organisations and HIV-positive individuals. It aims to explain how phylogenetic analysis should and should not be used in criminal trials for the reckless transmission of HIV."

- Useful quotation: "Although two individuals may have HIV that appear to be very closely related, this will not necessarily be unique to the two individuals but could extend to other people who are part of the same transmission network…Consequently, it can only be used to support other evidence."

The Microbial Forensic Use of HIV Sequences, G.H. Learn and J.I. Mullins, In: LeitnerT, FoleyB, HahnB et al. eds. HIV SEQUENCE COMPENDIUM 2003 (2003). Available at: http://www.hiv.lanl.gov/content/sequence/HIV/COMPENDIUM/2003/partI/Learn.pdf

This is a fairly dense scientific article on the forensics of HIV sequencing, with less of a focus on the legal concerns about the proof. However, it provides many details of the science, as well as good sources and some useful language.

- Useful quotation: "Even in cases in which patterns are consistent with a direction of transmission from the suspected donor to the alleged victim, it may be impossible to know with certainty that the transmission was directly from the donor to the victim without an intervening individual."

The chart below presents data on the prevalence, impact and treatment of HIV infection with parallel data on chronic diseases such as cardiovascular disease, diabetes, and Hepatitis C. This chart allows for the comparison of HIV to other chronic diseases that are common in high-income countries and that require lifelong clinical management. This data is not intended to diminish the personal and societal consequences of HIV infection, but to draw awareness to the equal or greater toll of other chronic diseases.

HIV and Chronic Disease in the United States

Disease	Prevalence	Social and Economic Burden of Disease[1]	Treatment	Disease Progression
HIV	• 0.6%[2]	• In 2002, annual direct and indirect costs of new HIV infections in the United States were estimated to total $36.4 billion[3]	• There is no cure for HIV infection[4] • HAART can suppress the virus, slow disease progression, and prolong life[5] • Adherence to HAART can decrease viral load and lower viral transmissibility[6]	• Untreated HIV infection will almost inevitably lead to illness and premature death[7] • HIV targets the immune system – it can begin degrading the immune system within weeks of infection, though some individuals do not experience symptoms for years[8] • Average life expectancy in the United States after diagnosis is 22.5 years[9] • HIV infection can increase vulnerability to cardiovascular disease, kidney disease, liver disease, and cancer[10]
Hepatitis C	• 1.5% (overall prevalence)[11]	• Direct health care costs associated with Hepatitis C predicted to reach $10.7 billion in the United States between 2010 and 2019[12]	• Antiviral drug therapy can cure Hepatitis C[13] • Length of treatment regimens, drug side effects, and drug availability often impede curing Hepatitis C and lead to development of chronic disease[14]	• Symptoms of initial Hepatitis C infection include fever, fatigue, nausea, vomiting, decline in appetite, abdominal pain, discoloration of urine and feces, joint pain, and jaundice[15] • Symptoms in chronically-infected people may indicate advanced liver disease[16] • 60.0–70.0% of chronically-infected individuals develop chronic liver disease[17] • 5.0-20.0% of chronically-infected individuals develop cirrhosis[18] • 1.0–5.0% of chronically-infected individuals die from cirrhosis or liver cancer[19]
Cardio-vascular Disease	• 33% (adult prevalence)[20]	• Accounted for 17,853,000 DALYs in high income countries in 2004[21]	• Behavior modifications, drug therapy, and operations such as bypass surgery or heart transplants may help control cardiovascular disease[22]	• Cardiovascular disease often manifests in acute events such as heart attack or stroke[23] • Behavioral risk factors, such as diet, physical inactivity, and tobacco use, are responsible for approximately 80% of CVD[24] • Elevated blood pressure, elevated blood glucose, elevated blood lipids, and obesity are all symptomatic of cardiovascular disease[25]
Diabetes	• 8.3% (overall prevalence)[26]	• Diabetes was estimated cost the United States $174 billion in direct health care and lost productivity expenditures[27]	• Behavior modifications, insulin treatment, and other drug regimens are used to regulate diabetes[28]	• 50% of people with diabetes die of cardiovascular disease[29] • On average, diabetics over the age of 50 die 8 years sooner than non-diabetic peers[30] • After 15 years of diabetes, approximately 2% of people become blind, and about 10% develop severe visual impairment due to diabetic retinopathy[31] • 10-20% of people with diabetes die of kidney failure[32] • Up to 50% of people with diabetes are affected by diabetic neuropathy, which increases the chance of foot ulcers and can lead to limb amputation [33] • Overall risk of dying among people with diabetes is at least double the risk of their peers without diabetes[34]

[1] Social burden of disease is represented by DALYs, disability-adjusted life years, which allow for the quantification of human disease toll. The World Health Organization, defines a DALY as "a time-based measure that combines years of life lost due to premature mortality and years of life lost due to time lived in states of less than full health." http://www.who.int/healthinfo/global_burden_disease/en/
[2] *Id* at 202
[3] Hutchinson, Angela B PhD, MPH, et al. "The Economic Burden of HIV in the United States in the Era of Highly Active Antiretroviral Therapy: Evidence of Continuing Racial and Ethnic Differences." JAIDS Journal of Acquired Immune Deficiency Syndromes: 1 December 2006 - Volume 43 - Issue 4 - pp 451-457.
[4] CDC. "Basic Information about HIV and AIDS." http://www.cdc.gov/hiv/topics/basic/index.htm
[5] World Health Organization. "HIV/AIDS: Antiretroviral therapy." http://www.who.int/hiv/topics/treatment/en/index.html
[6] Mark W. Hull and Julio Montaner. "Antiretroviral Therapy: A Key Component of a Comprehensive HIV Prevention Strategy" Current HIV/AIDS Report: Volume 8, Number 2, 85-93
[7] *The development of antiretroviral therapy and its impact on the HIV-1 AIDS pandemic,* Samuel Broder, M.D., Antiviral Research (2010).
[8] CDC. "Basic Information about HIV and AIDS." http://www.cdc.gov/hiv/topics/basic/index.htm
[9] Harrison K.M., Song R, Zhang X. Life Expectancy After HIV Diagnosis Based on National HIV Surveillance Data From 25 States, United States. *Journal of Acquired Immune Deficiency Syndromes (JAIDS)*. 2010: 53(1);124-130.
[10] Ibid
[11] PubMed Health. "Hepatitis C." http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001329/
[12] Wong JB, McQuillan GM, McHutchison JG, et al. Estimating future hepatitis C morbidity, mortality, and costs in the United States. Am J Public Health. 2000;90:1562-1569.
[13] World Health Organization. "Hepatitis C Fact sheet N°164 June 2011."
[14] Ibid
[15] Ibid
[16] Ibid
[17] Ibid
[18] Ibid
[19] Ibid
[20] Lloyd-Jones D, Adams RJ, Brown TM, et al. "Heart Disease and Stroke Statistics—2010 Update. A Report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee." *Circulation*. 2010;121:e1-e170.
[21] Health Statistics and Informatics Department, World Health Organization. *THE GLOBAL BURDEN OF DISEASE: 2004 UPDATE* (2008). http://www.who.int/evidence/bod
[22] World Health Organization. "Cardiovascular diseases (CVDs) Fact sheet N°317 January 2011." http://www.who.int/mediacentre/factsheets/fs317/en/http://www.who.int/mediacentre/factsheets/fs317/en/index.html
[23] World Health Organization. "Cardiovascular diseases (CVDs) Fact sheet N°317 January 2011." http://www.who.int/mediacentre/factsheets/fs317/en/
[24] Ibid
[25] Ibid
[26] CDC. "2011 National Diabetes Fact Sheet." http://www.cdc.gov/diabetes/pubs/factsheet11.htm
[27] CDC. "2011 National Diabetes Fact Sheet." http://www.cdc.gov/diabetes/pubs/factsheet11.htm
[28] WHO. "Diabetes," ibid
[29] Ibid
[30] Franco O, Steyerberg E, Hu F, Mackenbach J, Nusselder W. Associations of Diabetes Mellitus With Total Life Expectancy and Life Expectancy With and Without Cardiovascular Disease. Archives of Internal Medicine. 2007:167(11):1145-1151.
[31] Ibid
[32] Ibid
[33] Ibid
[34] Ibid

Employment Rights of People Living with HIV/AIDS

A Primer

THE CENTER FOR HIV LAW & POLICY

The Center for HIV Law and Policy
September 2010

HIV/AIDS and Employment Discrimination: A Primer

September 2010

MISSION STATEMENT

The Center for HIV Law and Policy is a national legal and policy resource and strategy center for people with HIV and their advocates. CHLP works to reduce the impact of HIV on vulnerable and marginalized communities and to secure the human rights of people affected by HIV.

We support and increase the advocacy power and HIV expertise of attorneys, community members, and service providers, and advance policy initiatives that are grounded in and uphold social justice, science, and the public health.

We do this by providing high-quality legal and policy materials through an accessible web-based resource bank; cultivating interdisciplinary support networks of experts, activists, and professionals; and coordinating a strategic leadership hub to track and advance advocacy on critical HIV legal, health, and human rights issues.

To learn more about our organization and access the resource bank
visit our website at www.hivlawandpolicy.org.

To contact us, email at info@hivlawandpolicy.org.
The Center for HIV Law and Policy
65 Broadway, Suite 832
New York, NY 10006
212.430.6733
212.430.6734 fax

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I. Introduction

People living with HIV, or people who have relationships with those living with HIV, often face significant discrimination in the workplace. While employers may attempt to justify this discrimination by referencing the need for safety or by invoking non-discriminatory rationales, HIV status in itself is not a valid basis for limiting an individual's employment options. Employers' exclusions of workers living with HIV typically are based on stigma and significant ignorance about the routes and actual risks of HIV transmission. This ignorance, and the consequent limits on employment and training opportunities, has had devastating effects on the personal and professional lives of people living with HIV.

This primer outlines the essential elements of employment discrimination claims based on HIV status, and the many considerations advocates and people living with HIV should be aware of before and during employment, as well as when pursuing an employment discrimination claim.

A number of the topics addressed here, such as when HIV is a disability under federal and state law, could or have been the subject of additional, extensive analyses. There also are topics, such as how to establish disability when representing a group of individuals with HIV in a class action, that are not addressed here at all. Those more extensive discussions are beyond the scope of this primer, which is intended to arm the advocate with the basic understanding necessary to assess and undertake a case on behalf of individuals who experience unfair treatment in the workplace because they are living with HIV/AIDS.

II. Laws Prohibiting Discrimination Based on HIV/AIDS

People who experience employment discrimination on the basis of their HIV-positive status may seek legal remedies under one or more of the following three sources of anti-discrimination law:

- Americans with Disabilities Act of 1990, *as amended* (ADA)[1]
- Rehabilitation Act of 1973[2]
- State or local employment anti-discrimination statutes

This primer focuses primarily on the ADA and the Rehabilitation Act as the two most important federal nondiscrimination statutes that apply to employment.

A. Workplaces Covered

The ADA and the Rehabilitation Act are federal statutes that protect individuals with disabilities from discrimination in several contexts, including employment. Both statutes prohibit discriminatory conduct by employers, but they apply to different types of employers and workplaces.

The ADA provides broader coverage and applies to employers (both private and state and local governments), employment agencies, labor organizations, and labor-management committees,[3] but

[1] 42 U.S.C. §§ 12101 et seq. (2009).
[2] 29 U.S.C. §§ 701 et seq. (2009).
[3] *See* 42 U.S.C. § 12111(2); *see also* U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, THE ADA: YOUR RESPONSIBILITIES AS AN EMPLOYER, http://www.eeoc.gov/facts/ada17.html (last visited Aug. 30, 2010).

excludes federal agencies that are covered by the Rehabilitation Act.[4] The ADA also limits coverage to employers with 15 or more employees for each working day in each of 20 or more calendar weeks, as well as any agent of such an employer.[5]

The Rehabilitation Act provides narrower coverage and applies to federal contractors, employers receiving federal funding, federal agencies, and the U.S. Postal Service.[6] Within the Rehabilitation Act, Section 501[7] applies to federal executive agencies and the U.S. Postal Service,[8] Section 503 applies to private employers with U.S. government contracts exceeding $10,000,[9] and Section 504 applies to recipients of federal funds, such as educational and healthcare facilities, as well as programs or activities conducted by executive agencies, and the postal service.[10]

Employers that are not covered by federal law (for example, a private employer with less than 15 employees would not be covered under the ADA) may be covered under state or local nondiscrimination statutes, and thus those laws should be considered as well.

B. Federal Administrative Agency Enforcement

The U.S. Equal Employment Opportunity Commission (EEOC) is the federal agency charged with enforcing the employment-related sections of the Rehabilitation Act (§ 501) and ADA's Title I..[11] Title I of the ADA prohibits private and state and local government entities that employ fifteen or more employees from discriminating against qualified individuals with disabilities with respect to recruitment, the application process, hiring, advancement, and other terms, conditions, and privileges of employment.[12] Because the ADA establishes overlapping responsibilities in both the EEOC and the DOJ for employment by state and local governments, the federal enforcement effort of the EEOC and DOJ is coordinated to avoid duplication in investigative and enforcement activities.

Claimants bringing an action against a federal agency under the Rehabilitation Act[13] and all claimants bringing an action under the Rehabilitation Act or Title I of the ADA[14] against private or government employers must file a charge with the EEOC before they can file a private lawsuit in

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[4] 42 U.S.C. § 12111(5)(B).
[5] *Id.* § 12111(5)(A). State laws may cover entities smaller than the those covered by the federal statutes.
[6] 29 U.S.C. §§ 793, 794(a)-(b). *See also* U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, THE REHABILITATION ACT OF 1973: SECTIONS 501 AND 505, http://www.eeoc.gov/policy/rehab.html (last visited Aug. 30, 2010).
[7] Parts of the Rehabilitation Act are colloquially referred to by the section numbers contained in the original legislation, which do not correlate to the section numbers where the Act is codified in the United States Code.
[8] 29 U.S.C. § 791(b).
[9] *Id.* § 793.
[10] *Id.* § 794(a), (b).
[11] 42 U.S.C. §§ 12111, 12116. Under Title I, covered employers, including state and local government employers, must have at least 15 employees.
[12] *See* 42 U.S.C. § 12102. The Equal Employment Opportunity Commission has issued regulations implementing Title I of the ADA. Those regulations can be found at 29 C.F.R. Part 1630.
[13] 29 C.F.R. § 1614.105(a)(1); *see, e.g.*, Raines v. U.S. Dep't of Justice, 424 F. Supp. 2d 60, 66 (D.D.C. 2006). Non-federal employees may file a charge with the EEOC, but are not required to do so. *See* CHARLES R RICHE, MANUAL ON EMPLOYMENT DISCRIMINATION § 6:1 (Supp. June, 2009); U.S. Department of Justice, Civil Rights Division, A Guide to Disabilities Rights Laws (Sept. 2005), http://www.ada.gov/cguide.htm#anchor65610 (last visited Aug. 30, 2010).
[14] 42 U.S.C. § 2000e-5; *see* FEDERAL PROCEDURE, LAWYERS EDITION. § 50:205 (Supp. 2009).

court. The EEOC website provides information on how to file a charge with the EEOC.[15] Advocates considering filing a claim should also review the EEOC regulations implementing the ADA,[16] as well as the EEOC's interpretative guidance. In view of the disagreement among federal courts as to whether employment claims against government entities can be brought under Title II, and the availability of Title I for such claims, advocates are well-advised to rely on Title I for employment claims regardless of what type of defendant -- whether a government or a private entity -- is involved.[17]

Claims of employment discrimination under Title I of the ADA should be filed with the EEOC within 180 days of the alleged violation, although in states with deferral agreements with the EEOC, the time limit for filing charges is 300 days.[18] Advocates should consult applicable regulations for complaint filing deadlines for federal agencies and the U.S. Postal Service.[19]

C. State Law

Although this primer focuses on federal law, advocates should consider bringing claims under state or local employment discrimination laws, which may provide advantages not available under federal law. For example, state laws may cover workplaces not covered by federal law and provide broader remedies, including declaratory relief,[20] punitive damages,[21] damages for emotional distress,[22] or attorney's fees and costs.[23] Also, some state laws are more favorable to people living with HIV/AIDS, essentially declaring that HIV/AIDS is a *per se* disability, which is a condition that always qualifies as a disability under the statute at issue.[24] State laws may also prohibit discrimination on the basis of sexual orientation or gender identity and provide additional claims against the

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[15] EEOC, Filing a Charge of Employment Discrimination, http://www.eeoc.gov/facts/howtofil.html (last visited Aug. 30, 2010).

[16] *See* 29 C.F.R. pt. 1630.

[17] *University of Alabama v. Garrett,* 531 U.S. 356, 360 n. 1 (2001)(recognizing the split between the 11th and 9th Circuits and declining to address the issue of "whether Title II of the ADA, dealing with the 'services, programs, or activities of a public entity, 42 U.S.C. § 12132, is available for claims of employment discrimination when Title I of the ADA expressly deals with that subject"). Also *compare Bledsoe v. Palm Beach County Soil & Water Conservation Dist.*, 133 F.3d 816, 820 (11th Cir.) (holding that Title II covers employment discrimination), cert. denied 525 U.S. 826, 119 S.Ct. 72, 142 L.Ed.2d 57 (1998),FN5 with *Zimmerman v. Oregon Dep't of Justice*, 170 F.3d 1169, 1173 (9th Cir.1999) (holding that a public employee cannot bring a claim of employment discrimination under Title II). For a fuller discussion of how different federal district and appeals courts have ruled on employment claims under the different titles of the ADA, see *Brettler v. Purdue University* 408 F.Supp.2d 640 (N.D.Ind.2006).

[18] 42 U.S.C. § 2000e-5(e)(1). *See generally* 29 C.F.R. pt. 1601 (2009).

[19] *See generally* 29 C.F.R. pt. 1614 (2009).

[20] *See, e.g.*, "X" Corp. v. "Y" Person, 622 So. 2d 1098 (Fla. Dist. Ct. App. 1993) (per curiam) (declaring that employer was able to seek a declaratory judgment to determine applicability of HIV nondiscrimination law); *see also* AIDS AND THE LAW 3-149 (David Webber ed., 4th ed. Supp. 2010).

[21] *See, e.g.*, Cain v. Hyatt, 734 F. Supp. 671, 686-88 (E.D. Pa. 1990) (awarding plaintiff $50,000 in punitive damages under Pennsylvania Human Relations Act); *see also* Webber, *supra* note 20, at 3-149.

[22] *See, e.g.*, Club Swamp Annex v. White, 167 A.2d 400, 403-03 (N.Y. App. Div. 1990) (upholding $5,000 award for mental anguish as a part of compensatory damage award); *see also* Webber, *supra* note 20, at 3-149.

[23] *See, e.g.*, Racine Unified Sch. Dist. v. Labor & Indus. Review Comm'n, 476 N.W.2d 707, 725 (Wis. Ct. App. 1991) (upholding award of attorney's fees in successful suit against school district for policy of placing staff with AIDS on sick leave); *see also* Webber, *supra* note 20, at 3-149.

[24] *See, e.g.*, Benjamin R. v. Orkin Exterminating Co. Inc., 390 S.E.2d 814 (W. Va. 1990) (holding that any stage of HIV infection, including a person who is tested positive for the antibodies to such virus but who is asymptomatic, is a person with a "handicap" within the meaning of the West Virginia Code).

employer.[25] However, advocates should be aware that some states require the claimant to exhaust all administrative complaint procedures before a state statutory claim may be pursued in court. Consequently, a claimant may forfeit her/his state statutory claim if administrative procedures are not followed.[26] In other jurisdictions, the claimant must choose to bring a claim either under state law or administrative procedures, but not both.[27] Given that a state statutory claim may be advantageous—but possibly foreclosed if an administrative or federal claim is pursued—advocates should thoroughly assess each client's specific circumstances and the applicable state or local laws and procedures in the jurisdiction of the suit to determine the best legal strategy.

III. Proving HIV-Related Employment Discrimination Under Federal Disability Law

In 2008, Congress passed the ADA Amendments Act of 2008 (ADAAA)[28] in response to the many court rulings, including several by the U.S. Supreme Court,[29] that narrowly construed the definition of disability in the ADA and the Rehabilitation Act. The ADA amendments took effect on January 1, 2009.[30]

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[25] Sexual orientation and gender identity employment discrimination are not prohibited by federal law at the time of publication of this primer but may be covered by state law. A lesbian, gay, bisexual, or transgender (LGBT) claimant may have both a disability discrimination claim based on his/her HIV-positive status and a separate sexual orientation discrimination claim under state or local laws. Currently twelve states and the District of Columbia have statewide protection against both sexual orientation and gender identity employment discrimination: California, Colorado, Illinois, Iowa, Maine, Minnesota, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington. An additional nine states prohibit discrimination based on sexual orientation: Connecticut, Delaware, Hawaii, Maryland, Massachusetts, Nevada, New Hampshire, New York, and Wisconsin. Some states that do not have transgender-specific laws have had commissions, agencies, or attorney generals that have interpreted existing law to include some protection for transgender individuals: Connecticut, Florida, Hawaii, Massachusetts, and New York. HUMAN RIGHTS CAMPAIGN, STATEWIDE EMPLOYMENT LAWS & POLICIES (2009), http://www.hrc.org/documents/Employment_Laws_and_Policies.pdf (last visited Aug. 30, 2010). State-specific laws may change and thus advocates should confirm the laws in their state.

[26] *See, e.g.*, Finley v. Giacobbe, 827 F. Supp. 215 (S.D.N.Y. 1993) (dismissing plaintiff's state law claim for failure to comply with state notice-of-claim statute, but allowing federal statutory and constitutional claims to proceed); M.A.E. v. Doe, 566 A.2d 285 (Pa. Super. Ct. 1989) (dismissing claim for failure to exhaust administrative remedies). *See also* Webber, *supra* note 20, at 3-149.

[27] *See, e.g.*, Hermann v. Fairleigh Dickinson Univ., 444 A.2d 614 (N.J. Super. Ct. 1982) (dismissing claim because plaintiff chose in first instance to pursue administrative remedy and abandoned her appeal from its finding, thus barring her from judicial remedy). *See also* Webber, *supra* note 20, at 3-149.

[28] Pub. L. No. 110-325, 2008 U.S.C.C.A.N. (122 Stat.) 3553. For a detailed discussion of the ADA Amendments Act in regard to HIV discrimination claims, including its legislative history, see AIDS AND THE LAW § 3.2[D], at 3-32 to 3-38 (David W. Webber ed., 4th ed. Supp. 2010).

[29] The ADAAA explicitly overruled the Supreme Court's decisions in *Sutton v. United Airlines, Inc.,* 527 U.S. 471 (1999) and *Toyota Motor Manufacturing, Inc. v. Williams,* 534 U.S. 184 (2002).

[30] As of the time of this primer's publication, few cases have had the opportunity to apply the ADAAA. *See, e.g.*, Franchi v. New Hampton Sch., No. 08-cv-395-JL, 2009 WL 2997625 at *4 (D.N.H. Sept. 18, 2009) (ADAAA specifies that major life activities include, but are not limited to eating); Green v. American Univ., No. 07-cv-52, 2009, WL 2569776 at *5 (D.D.C. Aug. 21, 2009) (ADAAA states that major life activities include, but are not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions); Chiesa v. N.Y. State Dep't of Labor, No. 1:06-CV-1549, 2009 WL 2344766 at *4 (N.D.N.Y. July 31, 2009) (under the ADAAA, standards of "significant restriction" or similar raised standards may not be used when determining the existence of a disability); Kemppainen v. Arkansas County Detention Ctr., 626 F.Supp.2d 672, 679 (S.D. Tex. 2009) (interpreting the ADAAA to amend the ADA to require the determination of whether an individual is disabled "without regard to the ameliorative effects of mitigation measures" but nevertheless to require the court to consider the ameliorative effects of the mitigating measures of ordinary eyeglasses or contact lenses in determining whether an impairment substantially limits a major life activity); Menchaca v. Maricopa Community College Dist., 595 F.Supp.2d 1063, 1068-69 (D. Ariz. 2009) (construing the definition of disability broadly under the ADA and

For claims arising *on or after* January 1, 2009 – the effective date of the 2008 ADA Amendments Act – there should be no dispute that individuals with HIV are covered under the ADA and the Rehabilitation Act, which prohibit most employers from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions, and privileges of employment.[31]

For claims arising *before* January 1, 2009, individuals with HIV should also be covered under the ADA and the Rehabilitation Act, although in several cases courts have ruled that persons with HIV are not covered. Advocates should thus consider which legal standard applies, based on the facts of the case, with proper consideration given to whether a discriminatory act taken before the effective date is continuing or ongoing, thus bringing it within the enhanced coverage. Employment applicants or employees seeking job benefits or advancement who were unlawfully discriminated against before January 1, 2009, may consider re-applying and thus potentially accruing a claim under the ADA as amended in the event that they are again discriminated against. The following discussion of these statutes will thus distinguish between the ADA and Rehabilitation Act pre- and post-amendment.

When interpreting either the ADA or the Rehabilitation Act, advocates should look to case law on both statutes. The ADA itself requires that it be interpreted not to apply less protection than the Rehabilitation Act or the regulations issued by the agencies in charge of enforcing it,[32] and many courts have interpreted the ADA consistently with interpretations of the Rehabilitation Act.[33] At the same time, the Rehabilitation Act was amended by the ADAAA so that the standards of proof for employment discrimination are the same as those laid out in the ADA.[34]

A. Elements of a Disability Discrimination Claim

The ADA and the Rehabilitation Act have the same elements of proof of unlawful discrimination. The crucial consideration for both statutes, however, is whether the claim is analyzed under the law before or after the effective date (January 1, 2009) of the ADA Amendments Act of 2008.

To establish a *prima facie* case of employment discrimination, a plaintiff must prove that he:

- has a disability;
- is a qualified individual; and

ADAAA). While several cases have acknowledged the passage of the ADAAA and even commented on its effects, most of these cases have not applied the ADAAA because it was not yet in effect when the facts at issue took place. *See, e.g.*, Hohider v. United Parcel Service, 574 F.3d 169, 188 n.17 (3d Cir. 2009) (not applying the ADAAA, but describing how the ADAAA amends the scope of being "regarded as" having a disability under the ADA); Rohr v. Salt River Project Agricultural Imp. & Power Dist, 555 F.3d 850 (9th Cir. 2009) (not applying the ADAAA, but noting that the ADAAA expands the class of persons who are entitled to protection under the ADA).

[31] 42 U.S.C. § 12112(a), (b)(1)-(4); *see also* U.S. DEPARTMENT OF JUSTICE, CIVIL RIGHTS DIVISION, A GUIDE TO DISABILITY RIGHTS LAW (2005), *available at* http://www.ada.gov/cguide.htm (last visited Aug. 30, 2009).

[32] 42 U.S.C. § 12201(a).

[33] *See, e.g.*, Ennis v. Nat'l Ass'n of Bus. and Educ. Radio, Inc., 53 F.3d 55, 57 (4th Cir. 1995) (stating that to the extent possible, the court will adjudicate ADA claims in a manner consistent with decisions interpreting the Rehabilitation Act); *see also* Doe v. University of Md. Med. Sys. Corp., 50 F.3d 1261, 1264 n.9 (4th Cir. 1995).

[34] 29 U.S.C. § 794(d).

- was discriminated against because of the disability.[35]

1. HIV as a Disability Under the ADA/Rehabilitation Act

No specific health or medical condition, including HIV or AIDS, is identified as a disability in the ADA or the Rehabilitation Act.[36] Instead, these statutes rely on the same generic definition of disability, although the ADA also protects persons with a known "relationship or association" with a person with a disability.[37]

The disability definition includes three elements (frequently referred to as "prongs"):

- a physical or mental impairment that substantially limits one or more major life activities;
- a record of such an impairment; or
- being regarded as having such an impairment.[38]

a. Post-ADA Amendments Act Claims

Establishing that a potential plaintiff is covered by the ADA is substantially easier for claims arising on or after the effective date (January 1, 2009) of the ADA Amendments Act of 2008 (ADAAA) than it is for claims under the ADA prior its amendment. The amendments change both the first (actual disability) and third ("regarded as" disabled) prongs, and plaintiffs with HIV should rely on both in proving their claims.

Under the first prong of the disability definition, plaintiffs must prove that they have a *physical* or *mental impairment*[39] that substantially limits a *major life activity*. The amended ADA significantly broadens this definition by adding an illustrative and nonexclusive list of major life activities, including "the operation of a major bodily function," which in turn is defined by a nonexclusive list of functions including "immune system" and "reproductive functions." Because of the effect of HIV infection on immune system function, and, for some plaintiffs, on reproductive function, all individuals with HIV infection should be able to prove that they have a substantial limitation on a major life activity. Next, because the amended ADA removes the effects of mitigating measures such a medications from consideration in determining whether an individual with HIV has a

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[35] AMERICANS WITH DISABILITIES: PRACTICE AND COMPLIANCE MANUAL § 1:237 (2003 Supp. 2009). As discussed *supra* notes 114-117 and accompanying test, the Rehabilitation Act has been interpreted by most courts to require that the disability be the sole reason for discrimination, whereas the ADA does not. *But see* Powell v. City of Pittsfield, 221 F. Supp. 2d 119, 149 (D. Mass. 2002).

[36] When the ADA was enacted in 1990, four of the six congressional committees that reviewed the law as a bill had considered the issue of HIV infection as a disability and all legislative reports that considered the issue concluded that HIV infection is an impairment under the ADA and assumed that the impairment caused by HIV is substantial. *See* Senate Comm. on Labor and Human Resources, Americans with Disabilities Act of 1989, S. REP. NO. 116, 101st Cong., 2d Sess. 8 (1989); *see also* H.R. Rep. No. 485, pt. 2, 101st Cong., 2d Sess. 51, *reprinted in* 1990 U.S.C.C.A.N. 303, 333; H.R. REP. NO. 485, pt. 3, 101st Cong., 2d Sess. 28, n.18. *See also* Webber, *supra* note 20, at 3-19 to -24. However, despite the discussions and intentions to include HIV/AIDS as conditions protected under the ADA and Rehabilitation Act, no reference to HIV/AIDS was included in those statutes.

[37] 42 U.S.C. § 12102; *compare* 29 U.S.C. § 705(20)(B).

[38] 42 U.S.C. § 12102(1).

[39] Prior to the enactment of the ADA Amendments Act, the U.S. Supreme Court held that HIV infection is an impairment. *Bragdon v. Abbott*, 524 U.S. 624, 637 (1998). The amendments thus resolve in the affirmative the remaining question of whether the impairment affects a major life activity and whether it is substantial in nature.

disability, the courts must view a plaintiff's HIV infection as though it were medically untreated. Similarly, if an individual with HIV illness experiences disabling symptoms that are "episodic or in remission," under the amended ADA, the courts must assess whether such an individual has an impairment that "would substantially limit a major life activity when active." Accordingly, even if an individual's HIV infection is asymptomatic, and thus did not impose a substantial limitation on any major life activity, evaluating it without regard to medical treatment or the episodic nature of life-threatening opportunistic infections should compel the conclusion that it is a disability. In sum, plaintiffs with HIV should specifically plead and be prepared to prove, through expert testimony if necessary, that they meet the amended disability definition, although in many if not all cases, there will be no reasonable basis to dispute whether a plaintiff with HIV is disabled and thus covered under the ADA.

The ADA amendments also make it considerably easier to establish a claim of discrimination based on the third, "regarded as" disabled, prong by requiring that for a valid claim, the plaintiff need only prove that discrimination resulted from an impairment or from the employer's perception that the employee has an impairment. Because there is no question that HIV infection is an impairment under the ADA,[40] if an employer discriminates on the basis of actual or perceived HIV status, then the employee can make a valid ADA claim without regard to whether the impairment limits or is perceived to limit a major life activity. This third prong remains important because a plaintiff who is *not* HIV positive, but is discriminated against solely because of an employer's erroneous suspicion or perception that she is, can make a claim under the ADA. Under the ADA amendments, however, employees who qualify as disabled solely under the "regarded as" prong are not entitled to reasonable accommodations.[41]

Because the ADA amendments did not directly change the second, "record of impairment," prong of the disability definition, that prong is covered below in the pre-ADA Amendments Act discussion. Advocates should note, however, that any record of HIV infection would constitute a disability, given the broadened definition of disability discussed above; there is no question that HIV infection, without more, is an impairment under the ADA and Rehabilitation Act.

Advocates for persons with HIV should also rely as a general matter on the direction given in the ADA amendments that the courts should construe the ADA "in favor of broad coverage of individuals under this Act, to the maximum extent permitted by the terms of this Act."[42]

The EEOC's proposed regulations for implementing the ADA amendments identifies HIV/AIDS, in effect, as a *per se* disability by stating that there are "impairments that will consistently meet the definition [of disability]" such as "HIV or AIDS, which substantially limit functions of the immune system."[43] Similarly, in its proposed definition of "major life activity," the EEOC stated that "the link between particular impairments and various major bodily functions should not be difficult to identify. For example . . . the Human Immunodeficiency Virus (HIV) affects functioning of the immune system."[44] Although the federal agency rule-making authority to define "disability" under

[40] *Bragdon v. Abbott*, 524 U.S. 624, 637 (1998).
[41] 42 U.S.C. § 12201(h).
[42] 42 U.S.C. § 12102.
[43] EEOC, *Regulations To Implement the Equal Employment Provisions of the Americans With Disabilities Act, as Amended*, 74 Fed. Reg. 48,431 at 48,441 (Sept. 23, 2009), *amending* 29 C.F.R. § 1630.2.
[44] 74 Fed. Reg. at 48,446.

the ADA was unclear, the amended ADA provides an explicit grant of rule-making authority to the EEOC to define that term.[45]

That HIV infection is a disability under the ADA was also the conclusion reached in *Horgan v. Simmons,*[46] one of the first reported HIV discrimination cases decided under the amended ADA. The court concluded that the plaintiff's HIV status was sufficient to bring him under the ADA's amended disability definition because the plaintiff's "HIV positive status substantially limits a major life activity: the function of his immune system."

b. Pre-ADA Amendments Act Claims

Although the 2008 amendments to the ADA and Rehabilitation Act make it easier to establish that HIV is a disability, there were many cases decided before the amendments that concluded that HIV is a disability. In light of the amendments, however, and the strong congressional disapproval of the handful of judicial rulings that interpreted the ADA narrowly on the question of HIV as a disability, cases under the ADA that arose prior to its amendment may now benefit from a broadened judicial view of the law, even though the amendments are not directly applicable to pre-amendment cases.

Proving that the claimant's HIV/AIDS status is a disability under the first prong of the disability definition is a three-step process that requires the claimant to show that he:

(1) has a *physical* or *mental impairment* that
(2) limits a *major life activity* and that
(3) the limitation is *substantial*.[47]

1) HIV Infection as an Impairment

Under *Bragdon v. Abbott*, HIV infection, whether symptomatic or asymptomatic, is always considered a physical impairment.[48] Although the Court held that HIV is always an impairment, it did not explicitly rule that HIV is in all cases a substantial limitation on a major life activity, but instead emphasized that ADA claims must be evaluated on a case by case basis.[49]

2) Major Life Activities Limited by HIV

Prior to its amendment, the ADA did not provide a definition of *major life activity*. In lieu of a statutory definition, federal enforcement agencies issued an illustrative, non-exhaustive list of major life activities: caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.[50] A Congressional committee report accompanying the ADA, however, included three additional activities in its list: participating in community activities; sexual

[45] Pub. L. No. 110-325, § 6(a)(2).
[46] No. 09 C 6796, 2010 U.S. Dist. LEXIS 36915, 2010 WL 1434317 (N.D. Ill. Apr. 12, 2010).
[47] 42 U.S.C. § 12102(2). *See also Bragdon*, 524 U.S. at 631. For a detailed discussion of HIV as a disability under the ADA prior to its amendment in 2008, see AIDS AND THE LAW § 3.2[E] at 3-38 to 3-75 (David W. Webber ed., 4th ed. Supp. 2010).
[48] *Id.* at 637 ("HIV infection satisfies the statutory and regulatory definition of a physical impairment during every stage of the disease.").
[49] *Id.* at 617-42.
[50] 45 C.F.R. § 84.3(j)(2)(ii); 28 C.F.R. § 41.31(b)(2); 29 C.F.R. § 1630.2(i).

functioning; and reproduction, procreation, and child bearing.[51] One of the disputed issues in ADA interpretation prior to its amendment is thus the meaning of this term.

The courts have primarily relied on three potentially interrelated major life activities as being limited by HIV: reproduction and sexual functioning;[52] social functioning and participation;[53] and caring for oneself.[54] Although reproduction and sexual functioning are well-established in case law as major life activities, the other activities are less well established. Additionally, some plaintiffs have successfully relied on working as a major life activity,[55] although there is a significant risk that a court will conclude that although working is a major life activity, the plaintiff's ability to work is not substantially limited.[56] Plaintiffs thus should develop their case theories in reliance on more than one major life activity.

3) HIV as a Substantial Limitation

The final step in establishing that a claimant has a disability under the first prong of the ADA's definition is proof that the impairment substantially limits the identified major life activity or activities. Reproduction has been the most frequently referenced major life activity that is substantially limited by HIV/AIDS. The plaintiff in *Bragdon*, for example, testified that her HIV infection controlled her decision not to have a child, and the Court agreed that this was a substantial limitation.[57] In regard to the major life activities of social functioning and participation, and caring for oneself, advocates should rely on the growing body of social science research that supports the

[51] House Labor Report at 52, 1990 U.S.C.C.A.N. at 334.
[52] *Bragdon*, 524 U.S. at 638 ("reproduction and the sexual dynamics surrounding it" identified as a major life activity).
[53] Hernandez v. Prudential Ins. Co., 977 F. Supp. 1160, 1163–65 (M.D. Fla. 1997) (identifying "fear [HIV] inspires in others" as limiting major life activities); Doe v. District of Columbia, 796 F. Supp. 559, 568 (D.D.C. 1992) (HIV as a substantial limitation on normal social relationships). *See also* Bragdon v. Abbott, 524 U.S. 624, 656 (Ginsburg, J., concurring) (HIV limits social functioning, accessing health care, and maintaining family relations).
[54] United States v. Happy Time Day Care Ctr., 6 F. Supp. 2d 1073, 1084 (W.D. Wis. 1998) (major life activity of caring for oneself substantially limited by HIV infection); Hernandez v. Prudential Ins. Co., 977 F. Supp. 1160, 1163–65 (M.D. Fla. 1997) (caring for oneself as major life activity); *see also* 524 U.S. 624, 656 (Ginsburg, J., concurring) (ability to care for oneself identified as a major life activity). *Cf.* St. John v. NCI Bldg. Sys., Inc., 537 F. Supp. 2d 848, 862 n.10 (S.D. Tex. 2008) (rejecting plaintiff's claim that having a regularly functioning lymphatic system is a major life activity that was substantially limited by HIV; limitations on lymphatic system function viewed as impairment, not major life activity).
[55] Giebeler v. M & B Assocs., 343 F.3d 1143, 147–48 (9th Cir. 2003) (in housing discrimination case, holding that an individual with AIDS was a person with a disability because of inability to work); MX Group, Inc. v. City of Covington, 106 F. Supp. 2d 914, 918 (E.D. Ky. 2000) (recovery from heroin addiction is accompanied by medical problems, including HIV infection, that are substantial impairments of major life activities including working), *aff'd,* 293 F.3d 326 (6th Cir. 2002); Wallengren v. Samuel French, Inc., 39 F. Supp. 2d 343, 347 (S.D.N.Y. 1999) (relying on EEOC regulation defining work as a major life activity and *Bragdon* as identifying substantial limitations resulting from HIV and AIDS); DiSanto v. McGraw-Hill, Inc., 97 Civ. 1090 (JGK), 1998 U.S. Dist. LEXIS 12382, 1998 WL 474136 (S.D.N.Y. Aug. 11, 1998) (plaintiff's allegation that his HIV illness was a substantial limitation on his major life activity of working, but required a reasonable accommodation, adequate to survive employer's summary judgment motion in HIV discrimination case); Byrd v. BT Foods, Inc., 948 So. 2d 921 (Fla. Dist. Ct. App. 2007) (reversing grant of summary judgment for the defendant employer, applying Florida law as consistent with that of the federal ADA and finding that the plaintiff's HIV illness, apparently as a result of the side effects of the plaintiff's medications, resulted in a substantial limitation on the major life activity of working).
[56] Doe v. Kohn, Nast, & Graf, P.C., 862 F. Supp. 1310 (E.D. Pa. 1994) (concluding that plaintiff's HIV infection imposed a substantial limitation on reproduction, but not on his ability to work).
[57] *Bragdon*, 524 U.S. at 641.

view that people with HIV experience significant limitations on their social participation and ability to care for themselves.[58]

The issue of whether an individual's choice not to engage in a major life activity – such as the employee whose HIV infection would substantially limit her ability to conceive and bear children, but who has decided not to engage in those activities for reasons other than her HIV infection – means that the major life activity in question is not substantially limited has been addressed in several conflicting rulings.[59]

4) Record of Impairment

The second ("record of impairment") prong of the disability definition is intended to protect people who have an error in their health care records or other documents, indicating that they have a disability when in fact they do not, or someone who has recovered from a disabling condition, but references to the condition remain in their records.[60] This definition of disability was relied on in *School Board of Nassau County v. Arline*,[61] where the Supreme Court held that claimant's hospitalization for tuberculosis in 1957 established that she had a "record of … impairment" and was therefore a handicapped individual under the Rehabilitation Act.[62] There is no requirement that the record of impairment reflect that the individual has a history of impairment. [63]

[58] *See, e.g.,* Lambda Legal Defense & Education Fund, The State of HIV Stigma and Discrimination in 2007: An Evidence Based Report (2007), *available at* http://www.lambdalegal.org/our-work/publications/general/2007-hiv-stigma-discrimination.html; Deborah Ho & Brad Sears, HIV Discrimination in Health Care Services in Los Angeles County: The Results of Three Testing Studies (2006), *available at* http://www.escholarship.org/uc/item/1bm2p4gv (documenting significant percentages of health care professionals refusing to provide services to patients with HIV); Deborah L. Brimlow et al., Stigma and HIV/AIDS: A Review of the Literature (2003), *available at* http://hab.hrsa.gov/publications/stigma/front.htm; Gregory M. Herek et al., *HIV-Related Stigma and Knowledge in the United States: Prevalence and Trends, 1991–1999,* 92 Am. J. Pub. Health 371 (2002), *available at* http://psychology.ucdavis.edu/rainbow/html/stigma_02_press.html (concluding that AIDS is stigmatized condition in the United States, based factors such as misapprehension of risk of transmission by casual social contact); CDC, *HIV-Related Knowledge and Stigma—United States, 2000,* 49 MMWR 1062 (2000) (documenting substantial minority of survey respondents with stigmatizing attitudes about HIV in correlation to level of misinformation about risk of casual transmission); Aaron G. Buseh & Patricia E. Stevens, *Constrained But Not Determined by Stigma: Resistance by African American Women Living with HIV,* 44 Women & Health 1 (2006) (describing HIV stigma experienced by African-American women); Debra A. Murphy et al., *Correlates of HIV-Related Stigma Among HIV-Positive Mothers and Their Uninfected Adolescent Children,* 44 Womens Health 19 (2006) (describing mothers with HIV experiencing high levels of HIV-related stigma).

[59] *Compare* Blanks v. Southwestern Bell Communications, Inc., 310 F.3d 398, 401 (5th Cir. 2002) (concluding that because plaintiff did not plan on having children, his major life activity of reproduction was not limited); Worster v. Carlson Wagon Lit Travel, Inc., 353 F. Supp. 2d 257 (D. Conn. 2005) (same), *aff'd on other grounds,* No. 05-0716-CV, 2006 WL 328289 (2d Cir. Feb. 13, 2006); Gutwaks v. Am. Airlines, Inc., No. 3:98-CV-2120-BF, 1999 U.S. Dist. LEXIS 16833, 1999 WL 1611328 (N.D. Tex. Sept. 2, 1999) (same) *with* Teachout v. N.Y. City Dep't of Educ., No. 04 Civ. 945 (GEL), 2006 U.S. Dist. LEXIS 7405, 2006 WL 452022 (S.D.N.Y. Feb. 22, 2006) (rejecting view that plaintiff's personal choices are relevant to determining substantial limitation on reproduction, but instead considering whether the plaintiff is biologically capable of reproduction and whether HIV infection is a limitation on that capability).

[60] Webber, *supra* note 20, at 3-66.

[61] 480 U.S. 273 (1987). *Arline* was decided under the Rehabilitation Act, but the same reasoning applies to ADA cases.

[62] 480 U.S. at 281.

[63] *Compare* Doe v. Kohn, Nast, & Graf, P.C., 862 F. Supp. 1310, 1322 (E.D. Pa. 1994).

5) Regarded As Having a Disability

Prior to the ADA amendments, an employee or applicant had to demonstrate that the employer regarded him as having an impairment that substantially limited a major life activity in order to establish a *prima facie* claim of a perceived disability under the ADA.[64] An individual is regarded as having an impairment when others treat him as having such an impairment.[65] The claimant does not have to show that he actually has HIV/AIDS, just that he was treated as if he had HIV/AIDS. At least one court has held that speculation that an employer knew or suspected the employee's HIV status based on rumors among employees is insufficient to establish the link.[66] It is therefore important to develop evidence that the employer suspected or "knew" that the claimant was HIV-positive or had AIDS, even if the knowledge is incorrect.

2. Qualified for the Job

Once the claimant has established that he has a disability under one or more of the three definitions discussed in detail above, either under the ADA as amended or prior to its amendment, he must show that he is a qualified individual who "with or without reasonable accommodation, can perform the *essential function* of the employment position."[67] The employer's description of the essential job functions is given consideration, but any written description used in advertising or interviewing applicants for the job will also be considered evidence of the essential functions of the job.[68] If the employer asserts that that a qualification is an essential function, he bears the burden of proof that its criteria are "job-related and based on business necessity."[69]

a. Individualized Inquiry Requirement

An employer's determination that the plaintiff is not qualified must be based on an individualized inquiry into the capabilities of the plaintiff.[70] In the context of HIV, an employer may not rely on generalized conclusions about the affect HIV could have on job performance. Rather, "the employer must conduct an individualized inquiry into the individual's actual medical condition, and the impact, if any, the condition might have on that individual's ability to perform the job in question."[71] This was precisely the type of inquiry that the Sixth Circuit found lacking in *Holiday v. Chattanooga*, in which a city withdrew its offer of a police officer position on the basis of a single doctor's opinion that the applicant was not strong enough to withstand the rigors of police work simply because of his HIV status.[72]

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[64] *See* Wooten v. Farmland Foods, 58 F.3d 382, 385 (8th Cir.1995) (quoting 42 U.S.C. § 12102(2)(C)).
[65] *See* Webb v. Mercy Hospital, 102 F.3d 958, 960 (8th Cir. 1996).
[66] *See* Roberts v. Unidynamics Corp., 126 F.3d 1088, 1093 (8th Cir. 1997) (citing Hedberg v. Indiana Bell Tel. Co., Inc., 47 F.3d 928, 932 (7th Cir. 1995)).
[67] 42 U.S.C. § 12111(8).
[68] *Id.*
[69] 42 U.S.C. § 12112(d)(4)(A). *See* Webber, *supra* note 30, at 3-77.
[70] *See* Sch. Bd. of Nassau County v. Arline, 480 U.S. 273, 287 (1987); *see also* Holiday v. Chattanooga, 206 F.3d 637, 643 (6th Cir. 2000); Harris v. Thigpen, 941 F.2d 1495, 1525 (11th Cir. 1991) (stating that an "individualized inquiry" is necessary to determine whether plaintiffs are "otherwise qualified").
[71] *Holiday*, 206 F.3d at 643.
[72] *Id.* at 641. Reversing summary judgment in favor of the city, the court noted that the physician's report in question provided no evidence that the doctor even attempted to determine whether the plaintiff experienced fatigue, sluggishness, or any other symptom of physical weakness; rather, it cited only the plaintiff's HIV-positive status for the conclusion that the plaintiff was not strong enough for police work. *Id.* at 644. Moreover, the plaintiff had provided

b. The Direct Threat Defense

An employer may also argue that an HIV-positive applicant or employee is not qualified based not on the person's particular skills or ability, but rather on the supposed risk that person poses to himself or to others. If a plaintiff's employment would pose "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation," then the plaintiff is not considered qualified for employment.[73] Workplaces in which there is a significant risk of HIV transmission are indeed rare; employers that might wish to argue that there is a risk of transmission – for example, to first aiders in the event of an injury posing exposure to an HIV positive employee's blood – are foreclosed from doing so by the Occupational Safety and Health Administration blood-borne pathogens standard,[74] which requires that employers provide a reasonably safe workplace by complying with "universal precautions" to prevent exposure to HIV or other blood-borne infections.

In the unusual case in which OSHA standards do not resolve the workplace safety issue, the risk of transmission will be analyzed under *School Board of Nassau County v. Arline*, in which the Supreme Court set forth four factors courts should consider when determining whether a person with a contagious disease poses a significant threat to the health and safety of others:

- the nature of the risk (how the disease is transmitted);
- the duration of the risk (how long is the carrier infectious);
- the severity of the risk (what is the potential harm to third parties); and
- the probability the disease will be transmitted and will cause varying degrees of harm.[75]

The Court affirmed the requirement that an individualized determination must be made, and cautioned courts to avoid conclusions based on generalizations and stereotypes.[76] Moreover, it instructed courts to rely on "the reasonable medical judgments of public health officials."[77]

While parties often agree on the first three factors, courts often must resolve parties' conflicting claims regarding the likelihood that the plaintiff could transmit HIV in the course of performing the

evidence that he was fit to perform the job; the plaintiff passed the physical agility and strength test administered by state law, and served as a police officer without any limitations on his job performance in another location after being rejected by the city. *Id.*

[73] 42 U.S.C. § 12113(b); 29 C.F.R. § 1630.15 (2009). In *Chevron U.S.A. Inc. v. Echazabal*, 536 U.S. 73 (2002), the Court held that the direct threat defense applies to health or safety threats to the individual employee or applicant for employment, not just to others in the workplace.

[74] 29 C.F.R. § 1910.1030 (2009).

[75] *Arline*, 480 U.S. at 288.

[76] "Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness. Even those who suffer or have recovered from such noninfectious diseases as epilepsy or cancer have faced discrimination based on the irrational fear that they might be contagious.…The fact that some persons who have contagious diseases may pose a serious health threat to others under certain circumstances does not justify excluding from the coverage of the Act all persons with actual or perceived contagious diseases. Such exclusion would mean that those accused of being contagious would never have the opportunity to have their condition evaluated in light of medical evidence and a determination made as to whether they were 'otherwise qualified.' Rather, they would be vulnerable to discrimination on the basis of mythology—precisely the type of injury Congress sought to prevent." *Id.* at 284-86.

[77] *Id.* at 288.

duties of the job.[78] The court's analysis of the risk of transmission must focus on the specific characteristics of the job at issue, rather than the general risk of transmission.[79] Thus the conclusion each court will reach will vary depending on the facts at hand, particularly the requirements and risks of the job and the most current scientific findings and medical recommendations with regard to HIV transmission.

Although each case is fact-specific, a few insights can be gleaned from past cases. Courts have found no significant threat where an HIV-positive employee would be engaging in mouth-to-mouth breathing during CPR, or would be engaged in the contact involved in child care.[80] Advocates should also find support in cases concerning the rights of HIV-positive children to attend schools or other programs that have held that the theoretical or remote possibility of transmission does not present a significant risk in a classroom setting, even where bleeding or biting have occurred.[81] Also, past cases can be distinguished based on new knowledge demonstrating that lower viral loads significantly decrease risk of transmission, allowing individuals, such as health care workers, with low viral loads to argue more persuasively that they are not a direct threat.[82]

Even though some case law in the context of food service is deferential to the employer,[83] the EEOC has published guidance for restaurants on complying with the ADA that makes clear that

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[78] *See* Estate of Mauro, 137 F.3d at 403 (focusing court's analysis on the probability of transmission); Doe v. Univ. of Md. Med. Sys. Corp., 50 F.3d 1261, 1265-66 (4th Cir. 1995) (plaintiff did not dispute the first three factors, but argued that the risk of transmission was so small that it could not be considered significant); Bradley v. Univ. of Texas M.D. Anderson Cancer Ctr., 3 F.3d 922, 924 (5th Cir. 1993) ("The disputed issue is the probability of transmitting the virus."); Doe v. Dist. of Columbia, 796 F. Supp. 559, 568-69 (D.D.C. 1992) (focusing on risk of transmission); Doe v. Washington Univ., 780 F. Supp. 628, 632 (E.D. Mo. 1991) ("The Court believes that it is the fourth factor, the probability the disease will be transmitted, that is really at issue.").

[79] *See* Harris v. Thigpen, 941 F.2d 1495, 1526-27 (11th Cir. 1991).

[80] *See, e.g.*, Chalk v. U.S. Dist. Court, 840 F.2d 701, 710-11 (9th Cir. 1988) (in context of school teacher); *Dist. of Columbia*, 796 F. Supp. 559, 563-64, 568-70 (in context of firefighter).

[81] *See, e.g.*, Doe v. Deer Mt. Day Camp, Inc., 682 F. Supp. 2d 324 (S.D.N.Y. 2010) (granting motion for summary judgment on direct threat defense in favor of 10-year old boy with HIV who sought access to a summer basketball camp); Martinez v. Sch. Bd. of Hillsborough County, 711 F. Supp. 1066, 1070-72 (M.D. Fla. 1989) (risk of transmission from saliva did not support segregation of HIV-positive child from classroom); Doe v. Dolton Elementary Sch. Dist. No. 148, 694 F. Supp. 440, 445 (N.D. Ill. 1988); Ray v. Sch. Dist. of DeSoto County, 666 F. Supp. 1524, 1535 (M.D. Fla. 1987); Thomas v. Atascadero Unified Sch. Dist., 662 F. Supp. 376, 380 (C.D. Cal. 1987); Dist. 27 Community Sch. Bd. v. Bd. of Educ., 502 N.Y.S.2d 325, 332 (N.Y. Sup. Ct. 1986); *but see* Montalvo v. Radcliffe, 167 F.3d 873, 878 (4th Cir. 1999) (HIV-positive child would pose a direct threat to the health and safety of classmates in a "hard style" martial arts class that involved frequent bloody injuries and body contact).

[82] Centers for Disease Control and Prevention, *Investigation of Patients Treated by an HIV-Infected Cardiolothoracic Surgeon—Israel, 2007: Editorial Note*, 57 MMWR 1413, 1415 (2009).

[83] *See* EEOC v. Prevo's Family Market, Inc., 135 F.3d 1089 (6th Cir. 1998). In *Prevo's*, the Sixth Circuit reversed a trial court judgment and vacated an award of punitive damages for an HIV-positive employee who was reassigned from his position in a produce department and whose continued employment was conditioned on his submission to a medical examination. As Judge Moore's dissent notes, however, the majority's opinion contradicts public health authorities as well as the intent of the ADA. The ADA requires that employers have relevant objective medical evidence that a food-handling employee poses a direct threat to others before reassigning the employee. Here, the employer obtained no such evidence, demonstrating that the employer acted out of the very fear and prejudice the ADA prohibits. Moreover, there was no need for the employer to conduct a medical examination to make a direct threat determination because there was ample objective medical evidence from public health authorities and expert testimony that an individual living with HIV working in the food service industry poses no threat of transmission and needs no restriction in employment. Furthermore, it was undisputed that any risk of transmission could have been further reduced with reasonable accommodations such as gloves and separate knives, which expert testimony supported undertaking among all employees to reduce the spread of all infectious diseases.

HIV cannot be transmitted through food, and an individual's HIV-status is not a valid basis on which to deny them employment in food service.[84] Similarly, in 2009, the U.S. Justice Department stated its position that the ADA prohibits Title II public entities from denying a person with HIV an occupational license or admission to a trade school because of his or her HIV status. To comply with the ADA, state licensing boards, if they require certification that licensees are free of any contagious, communicable, or infectious disease, they must be clear that such a certification excludes diseases, such as HIV, that are not transmitted through casual contact or through the usual practice of the occupation for which a license is required.[85]

In one line of cases limited to specific facts involving health care workers (HCWs), the courts have held that there is a significant threat in circumstances where the employee's job involves surgical procedures that put the employee in direct contact with both sharp objects and exposed areas of patients' bodies.[86] In resolving such claims in the future, one source of guidance courts should rely on are national and state guidelines for HIV-positive health care workers. In 1991, the Centers for Disease Control and Prevention (CDC) published *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*.[87] The CDC HCW Guidelines state that there is no basis to restrict the practice of HCWs infected with HIV who perform invasive procedures unless those invasive procedures fall into the smaller category of "exposure prone" invasive procedures, but fails to define "exposure prone." It recommends that HCWs living with HIV should seek counsel from an expert review panel before performing exposure prone procedures, but does not recommend mandatory testing of HCWs for HIV. Unfortunately, the CDC has not updated its HCW Guidelines since 1991, despite repeated calls revision in light of advances in medicine and science.[88] After the CDC published its HCW Guidelines, Congress required states to adopt either the CDC HCW Guidelines or equivalent standards.[89] Thus, advocates should consult and argue for reliance on the applicable state laws if they are more progressive and accommodating of an individual health care worker's situation.

3. Reasonable Accommodation

Even if a plaintiff is unable to perform the essential functions of the job—either as a direct result of the individual's disability or because doing so would present a significant risk of harm to others—the employer does not necessarily escape liability. An individual in these circumstances is still a qualified individual if the employer could make an accommodation that would allow an employee with a disability to perform the required job duties, as long as the requested accommodation is reasonable.

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[84] *See* U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, HOW TO COMPLY WITH THE AMERICANS WITH DISABILITIES ACT: A GUIDE FOR RESTAURANTS AND OTHER FOOD SERVICE EMPLOYERS (2004). As required by the ADA, the U.S. Department of Health and Human Services annually publishes a list of diseases that can be transmitted by the food supply, and HIV has never been on it. *See* U.S. Department of Health and Human Services, Diseases Transmitted Through the Food Supply, 74 Fed. Reg. 61,151 (Nov. 23, 2009).

[85] U.S. JUSTICE DEPARTMENT, THE AMERICANS WITH DISABILITIES ACT AND THE RIGHTS OF PERSONS WITH HIV/AIDS TO OBTAIN OCCUPATIONAL TRAINING AND STATE LICENSING, *available at* http://www.ada.gov/qahivaids_license.pdf (last visited Aug. 30, 2010).

[86] *See supra* note 81 *e.g.*, *Estate of Mauro*, 137 F.3d at 406-07; *Univ. of Md.*, 50 F.3d at 1266; *Bradley*, 3 F.3d at 924-25; *Washington Univ.*, 780 F. Supp. at 633-34.

[87] 40 MMWR RR-08 (1991).

[88] *See, e.g.*, Lawrence O. Gostin, A Proposed National Policy on Health Care Workers Living with HIV/AIDS and Other Blood-Borne Pathogens, 284 JAMA 1965 (2000).

[89] *See* CENTER FOR HIV LAW & POLICY, GUIDELINES FOR HIV-POSITIVE HEALTH CARE WORKERS (2008) *available at* http://www.hivlawandpolicy.org/resources/view/167 (providing a state-by-state description of guidelines).

The term "reasonable accommodation" may include changing existing facilities to be usable by individuals with disabilities,[90] job restructuring, part-time or modified work schedules, or reassignment to a vacant position.[91] An employer's duty to provide reasonable accommodation is only triggered when the employee requests one.[92] Thus, while many claimants fear that disclosure will provoke discriminatory treatment, disclosure can strengthen a potential discrimination case by establishing a factual record that the employer knew about his HIV/AIDS status and refused to provide reasonable accommodation.

A reasonable accommodation is not necessarily limited to requests that are directly related to the essential job function. In *Buckingham v. United States*, a postal worker with AIDS sued the U.S. Postal Service under the Rehabilitation Act for its refusal to transfer him to another location where he could obtain better medical treatment for his illness.[93] The Ninth Circuit Court of Appeals held that transfer for medical treatment was not a *per se* unreasonable accommodation, affirming the judgment of the lower court.[94]

If a plaintiff cannot perform all the job duties due to his or her disability, an employer is required to modify the non-essential duties of the position to accommodate the plaintiff.[95] Courts have held that one way an employer may accomplish this by reassigning an employee to a position that offers similar pay, benefits, and opportunities for advancement.[96] However, if there is no vacant position available for which the disabled employee is qualified, employers are not required to create a new position or bypass placement practices based on seniority to accommodate the disabled employee.[97]

An accommodation is *not* reasonable if it either imposes "undue hardship on the operation of the business"[98] of the employer or requires "a fundamental alteration in the nature of [the] program."[99] Whether an accommodation would require an undue financial and administrative burden is determined by considering the following four factors:

- the nature and cost of the accommodation needed;
- the overall financial resources of the facility or facilities involved in the provision of the reasonable accommodation; the number of persons employed at such facility; the effect on expenses and resources, or the impact otherwise of such accommodation upon the operation of the facility;
- the overall financial resources of the covered entity; the overall size of the business of a covered entity with respect to the number of its employees; the number, type, and location of its facilities; and
- the type of operation or operations of the covered entity, including the composition, structure, and functions of the workforce of such entity; the geographic separateness,

[90] 42 U.S.C. § 12111(9)(A).
[91] *Id.* § 12111(9)(B).
[92] *See, e.g.*, Jones v. United Parcel Serv., 214 F.3d 402, 407-08 (3d Cir. 2000).
[93] 998 F.2d 735 (9th Cir. 1993).
[94] *Id.* at 739-40.
[95] *See* Taylor v. Rice, 451 F.3d 898, 909-10 (D.C. Cir. 2006).
[96] *See, e.g.,* Doe v. Dekalb County Sch. Dist., 145 F.3d 1441, 1452 (11th Cir. 1998); Norville v. Staten Island Univ. Hosp., 196 F.3d 89, 99 (2d Cir. 1999).
[97] *See, e.g.,* Buskirk v. Apollo Metals, 307 F.3d 160, 169 (3d Cir. 2002).
[98] Southeastern Cmty. College v. Davis, 442 U.S. 397, 412 (1979); 42 U.S.C. § 12112(b)(5)(A).
[99] *Southeastern Cmty. College*, 442 U.S. at 410.

administrative, or fiscal relationship of the facility or facilities in question to the covered entity.[100]

4. Discriminatory Action

Once a claimant's HIV/AIDS status is established as a disability and the claimant shows that he is a qualified individual, the final step in establishing employment discrimination is demonstrating an adverse action that is based on the claimant's disability.[101] A plaintiff may demonstrate an adverse action in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions, and privileges of employment.[102] Moreover, although the ADA and the Rehabilitation Act do not explicitly provide for hostile work environment claims, several federal courts of appeal have either explicitly held or implied that plaintiffs may bring claims alleging a hostile work environment under the ADA and the Rehabilitation Act.[103]

A plaintiff may also demonstrate a discriminatory action by citing an employer's inquiries about a claimant's disability, depending on the context in which the inquiry was made. An employer is prohibited from asking during the interview process whether the applicant has a disability, but the employer can ask whether the applicant can perform essential job functions.[104] After an offer is made, the employer can require an HIV test if it is standard protocol to test all candidates, but the employer cannot single out some applicants to take an HIV test.[105] Additionally, employers must treat all test results as confidential medical records and maintain the records in separate files from the employee's main records.[106] Medical information about the employee can only be disclosed to:

- the employee's supervisors regarding necessary restrictions on the work or duties or necessary accommodations;
- first aid and safety personnel when appropriate, if the disability might require emergency treatment; and/or
- government officials investigating compliance.[107]

While post-hire examinations are allowed, an employer cannot inquire into the employee's HIV status or AIDS diagnosis unless it is "job-related and consistent with business necessity."[108] In *Gajda v. Manhattan and Bronx Surface Transit Authority*,[109] a transit employee indicated on his request for leave application that his health may not allow him to perform his job duties. The Second Circuit Court of Appeals held that the Transit Authority's need to determine whether a bus driver's declining health would interfere with his ability to perform his duties justified the Transit Authority's request for

[100] 42 U.S.C. § 12111(10)(B).
[101] As mentioned earlier, the Rehabilitation Act requires that the disability be the sole reason for the adverse action, whereas the ADA allows for a mixed-motive theory.
[102] 42 U.S.C. § 12112(a), (b)(1)-(4).
[103] *See* Lanman v. Johnson County, 393 F.3d 1151, 1155-56 (10th Cir. 2004); Neudecker v. Boisclair Corp., 351 F.3d 361, 364-65 (8th Cir. 2003); Shaver v. Indep. Stave Co., 350 F.3d 716, 719 (8th Cir. 2003); Flowers v. S. Reg'l Physician Servs. Inc., 247 F.3d 229, 234-35 (5th Cir. 2001); Fox v. Gen. Motors Corp., 247 F.3d 169, 176 (4th Cir. 2001); Walton v. Mental Health Ass'n, 168 F.3d 661, 666 (3d Cir. 1999); Silk v. City of Chicago, 194 F.3d 788, 803-04 (7th Cir. 1999).
[104] 42 U.S.C. § 12112(d)(2).
[105] *Id.* § 12112(d)(3)(A).
[106] *Id.* § 12112(d)(3)(B).
[107] *Id.* § 12112(d)(3)(B)(i)-(iii).
[108] *Id.* § 12112(d)(4)(A).
[109] 396 F.3d 187, 189 (2d. Cir. 2005) (per curiam).

information regarding the driver's HIV status.[110] Conversely, an employer may not seek out medical information regarding and employee's HIV status or make an employee submit to an HIV test merely to confirm suspicions that the employee has HIV or AIDS.[111]

In addition, failure to provide a reasonable accommodation that would allow an employee with a disability to perform the job functions, or refusal to hire an otherwise qualified individual in order to avoid providing reasonable accommodations are in themselves discriminatory actions.[112] The concept of reasonable accommodation and what qualifies as "reasonable" is discussed in the previous section.

One difference between the ADA and Section 504 of the Rehabilitation Act is that the latter statute includes a provision that no qualified person shall be discriminated against "solely by reason of her or his disability."[113] A few courts have interpreted this element literally and required an employee to prove that the individual's disability was the *only* reason for the discrimination.[114] Consequently, those courts hold that if an employer can show a nondiscriminatory motive for an employee's adverse treatment, the employee's disability discrimination claim fails.[115] Other courts, however, including the First Circuit Court of Appeals, have analyzed employer liability under the Rehabilitation Act when adverse treatment is "in whole or in part" due to an employee's disability, a view consistent with that of Congress in amending the statute in 1992.[116] The ADA does not have the "solely by reason of" language of the Rehabilitation Act and, as a result, courts have allowed for a mixed-motive theory for proof of discrimination under the ADA.[117] In reality, however, in cases in which the employer can offer a nondiscriminatory rationale for its decision, even when there is some evidence of discrimination, if the plaintiff cannot show that the nondiscriminatory rationale is pretextual, there is a significant risk that a court will grant summary judgment for the employer.

An employee may also demonstrate that he or she experienced discrimination in the workplace by reason of the employee's relationship or association with another person who has, or is perceived to have, a disability.[118]

5. Prior Claims for Disability Benefits

[110] *See id.* at 188-89. It is important to note that the court did not hold that the Gajda's HIV status in itself provided a reason to doubt his capacity to perform his job—rather it was Gajda's comments specifically calling his ability to work into question.
[111] *See* Doe v. Kohn Nast & Graf, P.C., 866 F. Supp. 190, 197 (E.D. Pa. 1994).
[112] *Id.* § 12112(b)(5).
[113] 29 U.S.C. § 794(a). *See also* Leckelt v. Bd. of Comm'rs of Hosp. Dist. No. 1, 909 F.2d. 820, 825-26 (1990). Courts are divided on whether to read "solely" into claims brought against federal employers under section 501 of the Rehabilitation Act. *See* Pinkerton v. Spellings, 529 F. 3d 513, 516 (5th Cir. 2008) (per curiam).
[114] *See, e.g.,* Parker v. Columbia Pictures Indus., 204 F.3d 326, 337 (2d Cir. 2000) (holding that employers can be liable for disability-based discrimination under the ADA when an employee's disability is one factor causing her adverse treatment, whereas liability lies under the Rehabilitation Act when disability is the "only factor" causing her adverse treatment).
[115] *See, e.g.*, Dratz v. Johnson, No. Civ-92-190-B, 1994 WL 846899, at *5 (W.D. Okla. 1994).
[116] *See* Oliveras-Sifre v. Puerto Rico Dept. of Health, 214 F.3d 23, 25 & n. 2 (1st. Cir. 2000); *see also* Powell v. City of Pittsfield, 221 F. Supp. 2d 119, 148-49 (D. Mass. 2002) (holding that Congress's 1992 Amendments to the Rehabilitation Act expressly reject the standard that an employee's disability must be the sole cause of his or her adverse treatment).
[117] *See, e.g.*, Parker v. Columbia Pictures Indus., 204 F.3d 326, 336-37 (2d Cir. 2000) (holding that although the ADA includes no explicit mixed-motive provision, a number of other circuits have held that the mixed-motive analysis available in the Title VII context applies equally to cases brought under the ADA).
[118] 42 U.S.C. § 12112(b)(4); *see also* Trujillo v. PacifiCorp, 524 F.3d 1149 (10th Cir. 2008); Ennis v. Nat'l Ass'n of Bus. and Educ. Radio, Inc., 53 F.3d 55 (4th Cir. 1995).

One additional factor to consider in evaluating a discrimination claim is whether the claimant has previously sought disability benefits as a result of limitations on his or her ability to work. Individuals pursuing discrimination claims or anticipating doing so should also be aware of the impact of filing a disability benefits claim, and should state, as appropriate depending on their health status, that their ability to work is determined by the availability of accommodations for their disability.

In order to obtain disability benefits, the claimant usually must have demonstrated an *inability* to work.[119] In contrast, a discrimination claim requires that the claimant show she is a "qualified individual" under the ADA by demonstrating the *ability* to perform the essential function of the employment position, with or without an accommodation.[120]

The U.S. Supreme Court addressed this issue in *Cleveland v. Policy Management Systems Corp.*,[121] holding that a claimant is not automatically estopped from pursuing an ADA claim just because the claimant had pursued or received SSDI benefits. The Court thus rejected the approach of some lower courts that had imposed strong presumption that disability claimants are unable to work.[122] As the Court noted, there are too many situations in which an SSDI claim and an ADA claim can comfortably exist side by side to allow such a presumption against ADA protection.[123] For example, because the Social Security Administration (SSA) does not take into account the possibility of reasonable accommodations in determining disability benefits eligibility, an ADA plaintiff's claim that she can perform her job *with* reasonable accommodation may well prove consistent with an SSDI/SSI claim that she could not perform her own job (or other jobs) *without* it.[124] An individual might qualify for SSDI under the SSA's administrative rules and yet, due to special individual circumstances, be capable of performing the essential functions of her job. Or her condition might have changed over time, so that a statement about her disability made at the time of her application for SSDI/SSI benefits does not reflect her capacities at the time of the relevant employment decision.[125] There also are provisions of the SSA that allow individuals to collect disability benefits while they are working.[126] However, if a claimant is bringing an ADA claim in addition to an SSDI benefit claim, the claimant will be required to reconcile that the two cases are consistent by showing that, despite the SSDI claim, the claimant is a qualified individual under the ADA.[127]

IV. Gender, Race, and Employment Discrimination

In addition to the stigma associated with a positive HIV status, women, transgender individuals, and people of color living with HIV may face additional obstacles to employment. Women living with HIV in the United States are disproportionately low-income women of color with parental

[119] *See* McNemar v. Disney Stores, Inc., 91 F.3d 610, 618 (3d Cir. 1996), *overruled by* Cleveland v. Policy Management Systems Corp., 526 U.S. 795 (1999).
[120] 42 U.S.C. § 12111(8).
[121] 526 U.S. 795 (1999).
[122] *Id.* at 797-98.
[123] *Id.* at 802-03.
[124] *Id.* at 803.
[125] *Id.* at 805.
[126] I*d.*
[127] *Id.* at 806.

responsibilities.[128] African Americans still face significant employment discrimination, which may be compounded by the fact that HIV disproportionately affects African Americans compared to whites, with African Americans making up roughly half the people living with HIV in the United States.[129] Women still confront workplace discrimination despite legislative efforts to reduce sexual harassment and sex-based discrepancies in wages, benefits, and hiring.[130] Transgender individuals, who face disproportionate HIV rates,[131] may also face barriers to employment due to the severe stigma surrounding their gender identity. A stable job is critical to these individuals' ability to manage their illness and care for their families.[132] Various federal, state, and municipal rules help eliminate—and provide remedies for individuals faced with—race and gender-based employment discrimination.

Title VII of the Civil Rights Act of 1964 prohibits non-federal employers of fifteen or more employees from discriminating against—or engaging in practices that have a discriminatory impact on—an individual because of the individual's sex or race.[133] It prohibits not only overt sex- and race-based discrimination, but also workplace harassment and adverse treatment based on sex- or race-based stereotypes.[134] Adverse treatment under Title VII can also include isolating employees, such as limiting contact with customers.[135] Adverse treatment decisions are not justified even when driven by business concerns (such as concerns about the effect on employee relations or negative reactions of clients or customers).[136] Title VII also prohibits discrimination on the basis of a medical condition which predominantly affects one race unless the practice is job related and consistent with business necessity.[137] For example, because sickle cell anemia predominantly affects African-Americans, Title VII prohibits an employment policy that excludes individuals with sickle cell anemia unless the

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[128] HENRY J. KAISER FAMILY FOUNDATION, HIV/AIDS POLICY FACT SHEET: WOMEN AND HIV/AIDS IN THE UNITED STATES 1, 2 (2008), http://www.kff.org/hivaids/upload/6092-061.pdf (last visited Aug. 30, 2010).
[129] *See* BLACK AIDS INSTITUTE, LEFT BEHIND: BLACK AMERICA: A NEGLECTED PRIORITY IN THE GLOBAL AIDS EPIDEMIC 16 (2008).
[130] In 2008, Women filed 11,662 claims for workplace sexual harassment and 6285 claims of pregnancy-based discrimination with the EEOC. See THE U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, SEXUAL HARASSMENT CHARGES: EEOC & FEPAS COMBINED: FY 1997-FY 2008, http://www.eeoc.gov/laws/types/sexual_harassment.cfm (last visited Aug. 30, 2010); THE U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, PREGNANCY DISCRIMINATION CHARGES: EEOC & FEPAS COMBINED: FY 1997-FY 2008, http://www.eeoc.gov/eeoc/statistics/enforcement/pregnancy.cfm (last visited Aug. 30, 2010).
[131] Jeffrey H. Herbst et al., *Estimating HIV Prevalence and Risk Behaviors of Transgender Persons in the United States: A Systematic Review*, 12 AIDS BEHAV. 1 (2008).
[132] Kenneth C. Hergenrather et al., *Employment-Seeking Behavior of Persons with HIV/AIDS: A Theory-Based Approach*, 70 J. OF REHABILITATION 22 (2004).
[133] Discriminatory practices include refusing to hire, firing, or discriminating "against any individual with respect to his [or her] compensation, terms, conditions, or privileges of employment" because of an individual's race or sex or "to limit, segregate, or classify [an employee or applicant] for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his [or her] status as an employee" because of an individual's race or sex. *See* 42 U.S.C. 2000e-2 (2009). The Equal Pay Act also prohibits employers from paying female employees less than male employees on the basis of sex when their jobs require equal skill, effort, and responsibility, and are performed under similar working conditions. *See* 29 U.S.C. § 206(d) (2009).
[134] *See* U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION (EEOC), FACTS ABOUT RACE/COLOR DISCRIMINATION (2008), available at http://www.eeoc.gov/facts/fs-race.html; Price Waterhouse v. Hopkins, 490 U.S. 228, 250-51 (1989) (recognizing employee's adverse treatment because of her failure to conform to stereotypes about femininity as sex-based discrimination); Burlington Industries, Inc. v. Ellerth, 524 U.S. 742, 752-54 (1998) (acknowledging that both quid pro quo and hostile work environment sexual harassment are prohibited under Title VII).
[135] *See* EEOC, *supra* note 134.
[136] *See id.*
[137] *See id.*

policy is job related and consistent with business necessity.[138] This may be relevant in the context of HIV, which disproportionately affects African Americans and certain other racial minorities. Included in Title VII's prohibition of sex-based discrimination is discrimination against women based on pregnancy, childbirth, and related medical conditions.[139] Under Title VII, employers may not fire or refuse of hire a woman because she is pregnant or may become pregnant, and they must apply the same standards to pregnant employees who take time off because of their pregnancy as they apply to other "temporarily disabled" employees.[140]

Unfortunately, courts have not consistently provided Title VII protection to transgender individuals. Most courts have interpreted "sex" to mean a person's biological sex rather than gender identity.[141] As a consequence, few courts have held that Title VII protects transgender individuals against discrimination based on their gender-identity.[142] However, some courts have relied on the Supreme Court's holding that Title VII prohibits employment discrimination based on an individual's nonconformity to gender stereotypes and interpreted Title VII to prohibit discrimination against transgender individuals.[143]

Employees of organizations that receive federal financial assistance may also be protected from race- and sex-based discrimination by Title VI and Title IX, respectively. Title VI prohibits discrimination on the basis of race, color, or national origin in programs and activities receiving federal financial assistance.[144] Title IX prohibits sex-based discrimination in education programs receiving federal financial assistance.[145] Title IX was patterned after Title VI and thus the two are often interpreted similarly, however, some important distinctions remain.[146] For example, unlike Title IX, Title VI statutorily restricts claims of employment discrimination to instances where the "primary objective" of the financial assistance is to provide employment.[147] The U.S. Department of Justice has issued legal guides to both statutes, which are available on its website.[148]

The Constitution also offers some protection in the context of employment. The Equal Protection Clause of the Fourteenth Amendment prohibits governments, including the federal government, from purposefully discriminating against employees on the basis of race, alienage, or national origin unless the government can demonstrate that the discrimination is narrowly tailored to further a

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138 *See id.*

139 *See* 42 U.S.C. 2000e(k) (2009). Pregnancy discrimination has been interpreted to include discrimination against unwed mothers in the hiring process. *See* King v. Trans World Airlines, Inc., 738 F.2d 255 (8th Cir.1984).

140 *See* Susan M. Omilian & Jean P. Kamp, Sex-Based Employment Discrimination § 20:1 (2009); THE U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, FACTS ABOUT PREGNANCY DISCRIMINATION (2008), *available at* http://www.eeoc.gov/facts/fs-preg.html (last visited Aug. 30, 2010).

141 Katie Koch & Richard Bales, *Transgender Employment Discrimination*, 17 UCLA WOMEN'S L.J. 243, 246-47 (2008).

142 *See id.* at 250.

143 *See, e.g.*, Smith v. City of Salem, 369 F.3d 912, 918 (6th Cir. 2004).

144 42 U.S.C. § 2000d.

145 20 U.S.C. §1681 *et seq.*

146 Grove City College v. Bell, 465 U.S. 555, 566 (1984); North Haven v. Bell, 456 U.S. 512, 529-30 (1982) ("The meaning and applicability of Title VI are useful guides in construing Title IX, therefore, only to the extent that the language and history of Title IX do not suggest a contrary interpretation.")

147 42 U.S.C. § 2000d-3.

148 U.S. DEP'T OF JUSTICE, CIVIL RIGHTS DIVISION, TITLE VI LEGAL MANUAL (2001), *available at* http://www.justice.gov/crt/cor/coord/vimanual.php#IX.%20Employment%20Coverage (last visited Aug. 30, 2010); U.S. DEP'T OF JUSTICE, CIVIL RIGHTS DIVISION, TITLE IX LEGAL MANUAL (2001), *available at* http://www.justice.gov/crt/cor/coord/ixlegal.php#82 (last visited Aug. 30, 2010).

compelling state interest—an exceedingly high bar.[149] The Equal Protection Clause also prohibits governments from discriminating against employees based on sex unless the discriminatory action is closely and substantially related to an important government interest.[150] A small number of courts have interpreted the Equal Protection Clause as prohibiting the state from discriminating against transgender individuals in the employment context.[151]

In addition to these federal protections, at least eight states and numerous municipalities have anti-discrimination laws that specifically protect—or that courts have interpreted as protecting—transgender individuals from work place discrimination.[152] Three additional states have executive orders preventing public employees from such discrimination.[153] Furthermore, while the ADA and Rehabilitation Act do not recognize gender-identity-disorder as a disability,[154] some state courts have allowed transgender individuals to bring employment discrimination claims under state disability statutes.[155]

While, at the time of publication, it had not yet been passed, proposed federal legislation may offer additional protections in the future. Versions of the Employment Non-Discrimination Act (ENDA) introduced in Congress for the last several years would explicitly prohibit employment discrimination on the basis of gender identity.[156]

V. International Human Rights Law and Employment Discrimination

International human rights law can be a useful tool to advocate for the employment rights of persons living with HIV/AIDS. The international human rights framework prohibits a person's right to work from being impeded on the basis of their illness. This section provides specific background information and guidance on how international human rights law can strengthen domestic protections of the rights to work and equal treatment in employment.

A. International Human Rights Law in the U.S. Courts

Before discussing substantive international norms, it is necessary to understand how they can be used. This subsection briefly outlines how advocates use these international human rights norms in U.S. courts.

The human rights norms discussed below stem from several sources. Several are derived from

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149 Attorney General of N.Y. v. Soto-Lopez, 476 U.S. 898, 906 n.6 (1986).
150 *See* Personnel Adm'r of Massachusetts v. Feeney, 442 U.S. 256, 273 (1979).
151 *See* Omilian & Kamp, *supra* note 140, at § 28:5; *see, e.g.*, Smith v. City of Salem, 378 F.3d 566, 577-78 (6th Cir. 2004).
152 TRANSGENDER LAW & POLICY INSTITUTE, SCOPE OF EXPLICITLY TRANSGENDER-INCLUSIVE ANTI-DISCRIMINATION STATUTES (2008), http://www.thetaskforce.org/downloads/reports/fact_sheets/TI_antidisc_laws_7_08.pdf; Omilian &. Kamp, *supra* note 140, at § 28:4.
153 *See* Omilian &. Kamp, *supra* note 140, at § 28:4.
154 *See* 42 U.S.C. § 12211(b); 29 U.S.C. § 705(20)(F).
155 *See* Omilian &. Kamp, *supra* note 140, at § 28:6 (listing Florida, Illinois, Massachusetts, New Hampshire, New Jersey, New York, and Washington as states where courts or administrative agencies have ruled that transsexuality is a disability under their state statutes).
156 *See* S.1584, 111th Cong. (2009). The House of Representatives passed a version of ENDA in 2007 that would have prohibited discrimination based on sexual orientation, but the provisions to protect transgender individuals from discrimination based on their gender identity were stricken from the bill. *See* H.R. 3685, 110th Cong. (2007).

treaties, also known as "conventions," which the United States has either signed and ratified or signed without ratifying. Under international law, the United States is bound to uphold obligations under the treaties it has ratified. Where the United States has signed but not ratified a treaty, it is obligated not to act contrary to the purpose of the convention under Article 18 of the Vienna Convention on the Law of Treaties.[157] Another source of international law is "customary international law"—norms established by the customs of nations,[158] which may also be reflected in treaties, declarations, and other international agreements. Finally, this section also cites documents that are non-binding in themselves but that interpret binding treaty obligations or customary international law.

The role of these international obligations in U.S. law is complex and often contradictory. Under U.S. law, treaties and customary international law are binding, but do not necessarily give rise to a private right of action. The Constitution declares that treaties are the "supreme Law of the Land"[159] and federal common law has accorded the same status to customary international law.[160] However, it is difficult to bring private causes of action in U.S. courts under international law because of significant procedural obstacles. For example, the United States has declared most treaties "non-self-executing," meaning that ratification in itself does not create a private cause of action under the treaty. Moreover, the United States often ratifies treaties with "reservations" limiting their legal effect and ability to be enforced through private actions in courts. As a result, while the U.S. is bound by the treaties it ratifies and by customary international law, it is difficult to enforce international law in U.S. courts.

Even without creating a private cause of action, international human rights law may still play a vital role in protecting the employment rights of people living with HIV/AIDS. Public interest lawyers have successfully used international human rights treaties and other documents interpreting international human rights law to inform judges' decisions by framing domestic legal issues in a broader international context.[161] Many courts, including the Supreme Court, have been receptive to domestic legal arguments that incorporate international human rights norms as a source of support. The Supreme Court has cited international human rights standards in finding unconstitutional laws prohibiting sodomy,[162] and laws allowing the imposition of the death penalty for juveniles[163] and defendants with mental retardation,[164] and in upholding race-conscious admissions policies in higher education.[165]

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[157] The Vienna Convention on the Law of Treaties is a separate treaty governing treaty interpretation and adherence that the United States has ratified. Vienna Convention on the Law of Treaties art. 18, May 23, 1969, 1155 U.N.T.S. 331, 336 (entered into force on Jan., 27, 1980); *see also* Jean Koh Peters, *How Children Are Heard in Child Protective Proceedings, in the United States and around the World in 2005: Survey Findings, Initial Observations, and Areas for Further Study*, 6 NEV. L.J. 966, 969 (2006).

[158] U.N. Charter, art. 38, para. 1(b).

[159] U.S. CONST., art. VI, cl. 2.

[160] *See* RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW OF THE UNITED STATES § 102 cmt. j. (1987); *see also* Scott L. Cummings, *The Internationalization of Public Interest Law*, 57 DUKE L. J. 891, 983-84 (2008); *cf.* Beharry v. Reno, 183 F. Supp. 2d 584, 597-601 (E.D.N.Y. 2002) (stating that the Convention on the Rights of the Child is binding on U.S. courts as a source of customary international law), *rev'd on other grounds*, Beharry v. Ashcroft, 329 F.3d 51 (2d Cir. 2003).

[161] *See* Cummings, *supra* note 160, at 985-87.

[162] Lawrence v. Texas, 539 U.S. 558, 573 (2003).

[163] Roper v Simmons, 543 U.S. 551, 575-78 (2005).

[164] Atkins v. Virginia, 536 U.S. 304, 316 n.21 (2002).

[165] Grutter v. Bollinger, 539 U.S. 306, 344 (2003) (Ginsburg, J., concurring).

The sources of international human rights norms are not limited to treaties that the United States has ratified. While ratification demonstrates the formal incorporation of an international agreement into U.S. law, courts have also relied upon non-ratified treaties, customary international law, and general state practice in their decisions. For example, in *Roper v. Simmons*, the Supreme Court cited the Convention on the Rights of the Child (CRC), a treaty that the U.S. has not ratified but which is widely acknowledged as customary international law,[166] in determining that the execution of minors is unconstitutional.[167] The Court also looked to the practice of other states in making its determination.[168] At least one federal court in the United States has explicitly cited sections of the CRC as customary international law binding on United States courts.[169] Thus, international human rights norms may be particularly useful for framing issues in the context of international practice where a U.S.-based practice falls out of line with the general international consensus.[170]

B. International Human Rights Norms Concerning the Rights to Work and Equal Treatment in Employment

International human rights law supports the rights of persons living with HIV/AIDS to work and protects them from discrimination on the basis of their illness in the work place.[171] These rights are protected by numerous provisions of international human rights instruments, several of which are outlined below:

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166 *See, e.g.*, Barbara Atwood, *The Voice of the Indian Child: Strengthening the Indian Child Welfare Act through Children's Participation*, 50 ARIZ. L. REV. 127, 139-40 (2008) (citing the Convention as the "consensus of world opinion regarding children's rights")

167 543 U.S. at 575-78.

168 *See id.*

169 *See Beharry*, 183 F. Supp. 2d at 600-01.

170 *See* Sarah H. Cleveland, *Our International Constitution*, 31 YALE J. INT'L L. 1, 80 (2006) (noting that international human rights norms are relevant to jurisprudence determining whether a particular form of conduct is "arbitrary and conscience-shocking" or is "implicit in the concept of ordered liberty").

171 "The Commission on Human Rights has confirmed that 'other status' in non-discrimination provisions is to be interpreted to include health status, including HIV/AIDS." Office of the High Comm'r for Human Rights & Joint U.N. Programme on HIV/ AIDS (UNAIDS), *International Guidelines on HIV/AIDS and Human Rights*, ¶ 108, U.N. Doc. HR/PUB/06/9 (2006) [hereinafter *International Guidelines*]. UNAIDS brings together ten organizations of the United Nations system: the United Nations High Commissioner for Refugees, the United Nations Children's Fund, the United Nations World Food Programme, the United Nations Development Programme, the United Nations Population Fund, the United Nations Office on Drugs and Crime, the International Labour Organization, the United Nations Educational, Scientific, and Cultural Organization, the World Health Organization, and the World Bank.

Protected Right	International Human Rights Instrument	Corresponding Obligations of the United States
The right to non-discrimination, equal protection, and equality before the law	• Art. 7 of the Universal Declaration of Human Rights ("Universal Declaration")[172] • Art. 3 and Art. 26 of the International Covenant on Civil and Political Rights ("ICCPR")[173] • The Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW")[174] • Art. 5 of the International Convention on the Elimination of All Forms of Racial Discrimination ("ICERD")[175] • Art. 5 of the Convention on the Rights of Persons with Disabilities ("CRPD")[176]	• The Universal Declaration is non-binding, but is considered customary international law. • The United States has signed and ratified the ICCPR, making it binding on the United States. • The United States has signed but not ratified the CEDAW, and thus has an obligation not to act contrary to the purpose of the convention under Article 18 of the Vienna Convention. • The United States has signed and ratified the ICERD, making it binding on the United States. • The United States has signed but not ratified the CRPD, and thus has an obligation not to act contrary to the purpose of the convention under Article 18 of the Vienna Convention.
The right to work.	• Art. 23(1) of the Universal Declaration • Art. 6 of the International Covenant on Economic, Social and Cultural Rights ("ICESCR") • Art. 11(1)(a) of the CEDAW • Art. 27 of the CRPD • Art. 5(e)(i) of the ICERD • Art. 32 of the Convention on the Rights of the Child ("CRC")	• See Universal Declaration above. • The United States has signed but not ratified the ICESCR, and thus has an obligation not to act contrary to the purpose of the convention under Article 18 of the Vienna Convention. • See CEDAW above. • See CRPD above. • See ICERD above. • The United States has signed but not ratified the CRC, and thus has an obligation not to act contrary to the purpose of the convention under Article 18 of the Vienna Convention.
The right to just and favorable conditions of employment	• Art. 23(1), (2) of the Universal Declaration • Art. 7 of the ICESCR • Art. 11(1)(f) of the CEDAW • Art. 27(1)(b) of the CRPD • Art. 5(e)(i) of the ICERD	• See Universal Declaration above. • See ICESCR above. • See CEDAW above. • See CRPD above. • See ICERD above.

[172] Universal Declaration of Human Rights, G.A. Res. 217A, U.N. GAOR 3d Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 12, 1948) [hereinafter Universal Declaration].
[173] International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR].
[174] Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, 1249 U.N.T.S. 13 [hereinafter CEDAW].
[175] International Convention on the Elimination of All Forms of Racial Discrimination, Mar. 7, 1966, 660 U.N.T.S. 195 [hereinafter ICERD].
[176] Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, U.N. Doc. A/61/611 [hereinafter CRPD]. The CRPD notes that, "[p]ersons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others," which would include many persons living with HIV/AIDS. *Id.* at Art. 1.

The right to equal pay and benefits for equal work	• Art. 23(2) of the Universal Declaration • Art. 7(a)(i) of the ICESCR • Art. 11(1)(d) of the CEDAW • Art. 27(1)(b) of the CRPD • Art. 5(e)(i) of the ICERD	• See Universal Declaration above. • See ICESCR above. • See CEDAW above. • See CRPD above. • See ICERD above.
The right to protection against harassment on the basis of a disability in employment	• Art. 27(1)(b) of the CRPD	• See CRPD above.
The right to an adequate standard of living, including security in the event of unemployment	• Art. 25(1) of the Universal Declaration • Art. 11(1)(e) of the CEDAW	• See Universal Declaration above. • See CEDAW above.

Because these international human rights instruments are written rather broadly, it is valuable to look to detailed authoritative interpretations of specific provisions from the instruments. These interpretive documents underscore protection of the rights to work and equal treatment in employment by international human rights law. The U.N. Committee on Economic, Social and Cultural Rights, the purpose of which is to provide authoritative guidance on the provisions of the ICESCR, notes that, "[t]he right to work is essential for realizing other human rights and forms an inseparable and inherent part of human dignity."[177] The Committee also views the right to work as broadly encompassing the rights to choose one's own work,[178] and to safe and prosperous work.[179] The Committee specifically calls upon states to, "take measures enabling persons with disabilities [including HIV/AIDS] to secure and retain appropriate employment and to progress in their occupational field, thus facilitating their integration or reintegration into society."[180] Finally, the Committee notes that all states have an affirmative obligation to respect, protect, and fulfill the right to work of all people.[181]

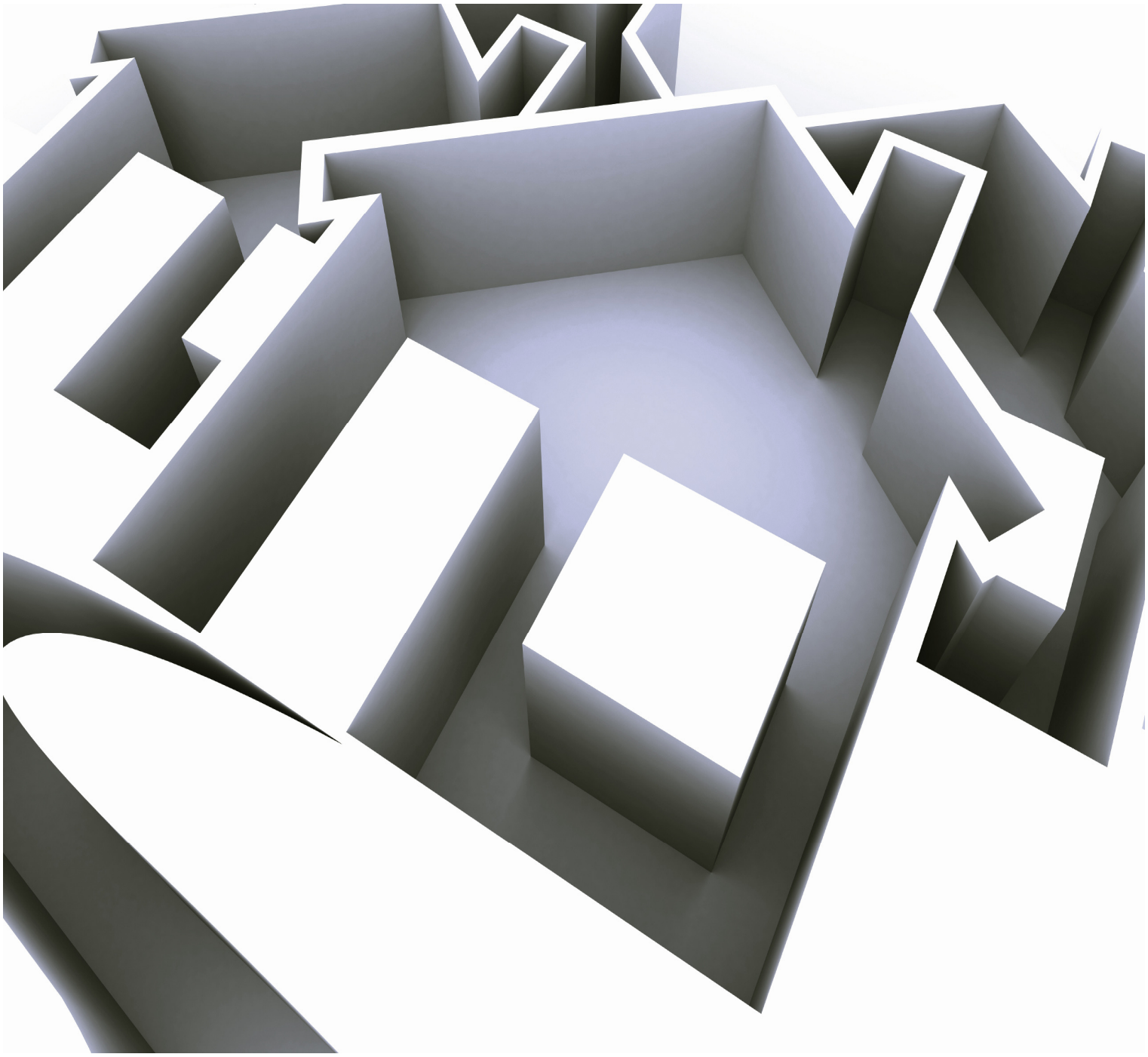
The rights to work and equal protection in employment are also embodied in the International Guidelines on HIV/AIDS and Human Rights ("International Guidelines"), a document put forth by the Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS ("UNAIDS").[182] Although the International Guidelines are not binding law like a ratified treaty, they are a persuasive interpretation of some of the rights embodied in international treaties. In this way, they are useful for putting the treaties into context. The International Guidelines direct states to ensure that, "persons living with HIV are allowed to work as long as they can carry out the functions of the job," and also that such persons are provided with reasonable accommodations.[183] The International Guidelines also direct states to create anti-discrimination protective laws for persons with HIV/AIDS that apply to both public and private sector employers.[184] The International Guidelines advocate specific protections for employees, such as: freedom from HIV screening prior to employment, promotion, training, or benefits;

[177] U.N. Comm. on Economic, Social and Cultural Rights, General Comment 18: The Right to work (art. 6), ¶ 1, U.N. Doc. E/C.12/GC/18 (Nov. 24, 2005).
[178] *See id.* ¶ 6.
[179] *See id.* ¶ 7.
[180] *Id.* ¶ 17.
[181] *Id.* ¶¶ 22, 23, 25, 26, 27, 28.
[182] *See, e.g.*, *International Guidelines*, *supra* note 171, ¶ 22(a)(i) (noting need for broad anti-discrimination laws that cover, among other things, employment).
[183] *Id.* ¶ 149.
[184] *Id.* ¶ 22.

confidentiality of all medical records; protection against termination for HIV-positive employees; adequate healthcare in or near the workplace; and protection from discrimination by co-workers, unions, employers, and clients.[185] For example, no type of employer could lawfully harass or refuse to promote an employee on the basis of the employee's HIV/AIDS status. The International Guidelines also call for employers to ensure that their employees have healthcare benefits that cover HIV-related treatments.[186]

These international instruments and accompanying interpretive documents demonstrate that international law requires nations to provide a broad range of protections for the rights of all persons, including those who are living with HIV/AIDS, to work and equal treatment in employment. As outlined in the chart above, these rights are derived from various international instruments, many of which are binding on the United States, and all of which obligate the United States, at a minimum, not to act in a contrary manner.

[185] *See id.* ¶ 22(d)(i-xii).
[186] *See id.* ¶ 34.



Housing Rights of People Living with HIV/AIDS: A Primer

The Center for HIV Law and Policy

March 2010

THE CENTER FOR HIV LAW & POLICY

MISSION STATEMENT

The Center for HIV Law and Policy is a national legal and policy resource and strategy center for people with HIV and their advocates. CHLP works to reduce the impact of HIV on vulnerable and marginalized communities and to secure the human rights of people affected by HIV.

We support and increase the advocacy power and HIV expertise of attorneys, community members and service providers, and advance policy initiatives that are grounded in and uphold social justice, science, and the public health.

We do this by providing high-quality legal and policy materials through an accessible web-based resource bank; cultivating interdisciplinary support networks of experts, activists, and professionals; and coordinating a strategic leadership hub to track and advance advocacy on critical HIV legal, health, and human rights issues.

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Email us at info@hivlawandpolicy.org.

Or write to:
The Center for HIV Law and Policy
65 Broadway, Suite 832
New York, NY 10006
212.430.6733
212.430.6734 fax

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I. Introduction

Safe, stable, and affordable housing is a basic human right. Such housing is vital to those living with HIV, who often must contend with compromised immune systems, complex drug regimens that often require refrigeration, and increased poverty due to disability and high medical costs. Nonetheless, finding and securing such housing can be extremely difficult for people living with HIV.

Discrimination poses a significant obstacle to people living with HIV, who often encounter prejudice when they attempt to rent an apartment or are denied an opportunity to live in a dwelling because of misinformed beliefs about the communicability of HIV. For others, the decision to live in a group home may foment intense community opposition; as a result, group homes are often zoned out of a city. People living with HIV may also be unable to meet minimum income qualifications because of their disability or may simply be unable to afford safe housing without assistance.

People living with HIV face many obstacles in obtaining the housing that is crucial to their well being. There are, however, federal, state, local, and common law protections that prohibit housing discrimination, as well as several federal funding programs that are designed to help people living with HIV obtain appropriate housing.

II. Housing Discrimination

A. The Fair Housing Act

1. Overview

The Fair Housing Act[1] (FHA) is the primary legal mechanism by which persons living with HIV can protect themselves against discrimination. The FHA makes it unlawful to discriminate in the sale or rental of, or otherwise make unavailable or deny, a dwelling to a buyer or renter because of his or her disability or the disability of a person associated with the buyer or renter.[2] The legislative history surrounding the 1988 Amendments to the FHA, which added people with disabilities to the list of protected classes, strongly suggests that Congress intended persons living with HIV to be considered handicapped under the FHA.[3] In its regulations implementing the FHA, the U.S. Department of Housing and Urban Development (HUD) explicitly included HIV infection within the definition of a "handicap."[4] Courts also have consistently concluded that HIV infection constitutes a disability under the FHA.[5]

[1] 42 U.S.C. §§ 3601-3631 (2008).

[2] *Id.* § 3604. The statute uses the language of "handicap," but courts use this interchangably with the preferable term "disability."

[3] *See* H.R. Rep. No. 100-711, at 18 (1988), *reprinted in* 1988 U.S.C.C.A.N. 2173, 2179.

[4] 24 C.F.R. § 100.201 (2008).

[5] *See, e.g.*, Giebeler v. M & B Assocs., 343 F.3d 1143, 1147 (9th Cir. 2003) (HIV infection can substantially limit major life activities); Baxter v. City of Belleville, 720 F. Supp. 720, 729-30 (S.D. Ill. 1989) (legislative record demonstrates Congressional intent to include persons with HIV and AIDS within the FHA); Support Ministries for Persons with AIDS, Inc. v. Vill. of Waterford, 808 F. Supp. 120, 130-132 (N.D.N.Y. 1992) (histories of the Americans with Disabilities Act and the Rehabilitation Act evidence that even asymptomatic HIV is a handicap under the FHA).

In order to bring a claim alleging a FHA violation, plaintiffs must demonstrate one of three actions on the part of the housing owner: (1) the contested action was animated by discriminatory intent, (2) the action disparately impacted people with disabilities, even if it was not animated by illegitimate motive,[6] or (3) the owner failed to make "reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford such person equal opportunity to use and enjoy such a dwelling."[7] Each of the FHA's prongs may be differentially implicated for people with HIV in obtaining and maintaining housing.

2. Obtaining Housing

The FHA provides protection against discrimination in attempting to rent or buy a home. Most refusal to rent claims fall under the discriminatory intent prong of the FHA. Plaintiffs generally need not show that their disability was the sole reason for the discrimination, only that it was one factor.[8] Because HIV status is not as readily apparent as other disabilities, courts have been willing to consider evidence that a defendant suspected a person had HIV or AIDS, even where there is sparse proof of actual knowledge. In *Neithamer v. Brenneman Property Service, Inc.*, for example, a court found that a plaintiff's mention of his HIV-positive partner's illness and death were sufficient to give rise to the inference that the defendants knew or suspected he was HIV-positive and that this was sufficient to preclude summary judgment.[9]

A person is also disabled under the FHA if they are regarded as having an impairment,[10] which may help prove violations where a person's HIV status may not be known to the defendant. In one case, the court found a possible violation of the FHA where a man living with AIDS was denied an apartment. The rental agency did not know that he had AIDS, but they did know he was receiving Social Security Disability benefits as part of his income. The court found that it was not necessary that the plaintiff's specific disability be known, so long he was regarded as having one.[11] Discrimination against those perceived to have HIV, even when they do not, may also be covered. In a case tried under New Jersey's Law Against Discrimination,[12] which is similar to the FHA in its protections, a court found that refusal to rent an apartment to three gay (but not HIV-positive) men for fear that they might acquire AIDS violated the law.[13]

Depending on the jurisdiction, the reasonable accommodations prong of the FHA might also be applicable if the plaintiff cannot rent or buy because the plaintiff's income is restricted due to his or her HIV status. In *Giebeler v. M & B Associates*, rental property owners refused to waive a no-cosigner policy for a man who had been disabled by his AIDS and thus did not meet the apartment's minimum income qualifications.[14] Because the plaintiff's limited income was due to his disability, the

[6] *See* Metro. Hous. Develop. Corp. v. Vill. of Arlington Heights, 558 F.2d 1283, 1288-90 (7th Cir. 1977).
[7] 42 U.S.C. § 3604.
[8] *See* Stewart B. McKinney Found., Inc. v. Town Plan and Zoning Comm'n of Fairfield, 790 F. Supp. 1197, 1210-11 (D. Conn. 1992); Ryan v. Ramsey, 936 F. Supp. 417, 423 (S.D. Tex. 1996).
[9] 81 F. Supp. 2d 1, 4-6 (D.D.C. 1999).
[10] 42 U.S.C. § 3604.
[11] Ryan v. Ramsey, 936 F. Supp. 417, 425-26 (S.D. Tex. 1996).
[12] N.J. STAT. ANN. § 10:5-1, *et seq.* (2008).
[13] Poff v. Caro, 549 A.2d 900, 903 (N.J. Super. Ct. Law Div. 1987).
[14] 343 F.3d 1143, 1144 (9th Cir. 2003).

Ninth Circuit found that defendant's refusal to waive the policy was a violation of the FHA.[15] In doing so the court rejected cases in both the Second and Seventh Circuits, which indicated that financial accommodation of people with disabilities was not required under the FHA.[16] Although it is unclear which Circuit's approach will prevail, it is notable that the contrary Second and Seventh Circuit cases were decided before the Supreme Court's decision in *U.S. Airways, Inc. v. Barnett,*[17] a case that considered the Americans with Disabilities Act and greatly influenced the Ninth Circuit's decision in *Giebeler.*[18] *Barnett* suggested that a reasonable accommodation may result in a preference for people with disabilities over those who are not, and also that accommodations may address not only the immediate effects of a disability, but also the practical effects.[19] The Ninth Circuit's reading of *Barnett* may provide means for people living with HIV to request and receive reasonable financial accommodations when searching for housing.[20]

3. Maintaining Housing

The FHA also provides some protection for people living with HIV once a proper dwelling has been secured, including in the area of evictions. For example, it is a violation of the FHA to treat a tenant in a discriminatory manner, which in itself can constitute constructive eviction—the unlawful act of making a dwelling uninhabitable by a tenant.[21] But a tenant's HIV status is not a blanket protection against eviction or other negative action if one of the FHA's three major prongs is not implicated.

The FHA also might prevent inquiries into a person's HIV status. HUD's implementing regulations make it unlawful under the FHA to inquire into the "nature or severity" of a person's disability,[22] which would seem to preclude inquiries into HIV status. However, the FHA and the implementing regulations also provide that it is not required to make a dwelling available to a tenant where doing so would pose a direct threat to the health or safety of others.[23] Some courts have interpreted this to mean that, where a tenant's HIV status might pose a "direct threat," inquiries about it may be acceptable. In *Kelly v. Williams*, for example, an administrative law judge found that because a defendant's minor children were responsible for cleaning the bathroom of the plaintiff, who had AIDS, his inquiry into the plaintiff's HIV status was protected by the direct threat exemption.[24] This may mean that, despite the facial prohibition, the FHA may not prohibit all inquiries into a person's HIV status.

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[15] *See id.* at 1155.

[16] *See id.* at 1153-55 (citing Hemisphere Bldg. Co. v. Vill. of Richton Park, 171 F.3d 437 (7th Cir. 1999) (accommodation is limited to accommodation of the disability itself, not subsequent financial situations); Salute v. Stratford Greens Garden Apartments, 136 F.3d 293 (2d Cir. 1998) (even where reduced income is the result of a disability, accommodation of a person's financial situation is outside the scope of the FHA).

[17] 535 U.S. 391 (2002).

[18] *See* 343 F.3d at 1149-51.

[19] 535 U.S. at 397-99.

[20] The court in *Giebeler* specifically disclaimed such requests as lowered rents for people with disabilities as likely being unreasonable though other requests for accommodations of financial policies may survive scrutiny. *See* 343 F.3d at 1154.

[21] *See* Kelly v. Williams*,* Fair Housing - Fair Lending (P-H) ¶ 25,007, 20 (H.U.D.A.L.J.1991).

[22] 24 C.F.R. § 100.202(c) (2008).

[23] 42 U.S.C. § 3604(f)(9) (2008); 24 C.F.R. § 100.202(d).

[24] Fair Housing - Fair Lending (P-H) ¶ 25,007 at 17. Note that while this court found the inquiry *itself* to be lawful under the FHA, the timing, content, and circumstance of the inquiry were not.

In the Ninth Circuit, *Giebeler* suggested that the reasonable accommodations prong of the FHA includes accommodations to the real and not merely obvious or immediate effects of a disability.[25] For persons living with HIV this might include accommodations that reflect the demands their increased need for medical care can create. In *McGary v. City of Portland,* a man disabled by AIDS was unable to comply with a city's nuisance abatement order to clear his yard, partly due to his hospitalization during the grace period.[26] The plaintiff had requested additional time to clear the yard because of his disability and hospitalization. The city denied the request and subsequently placed a lien on his house in order to collect the fine.[27] The Ninth Circuit did not rule on whether or not the request was a reasonable accommodation in remanding the case, but it did find that such a request might be reasonable as a matter of law and that placing a lien on the home interfered with plaintiff's use or enjoyment of the dwelling, thus making the denial of the accommodation a possible violation of the FHA.[28]

4. Group Home Restrictions

a. Zoning Laws

One area in which people living with HIV have consistently faced housing discrimination is in the administration of zoning laws, which are often used to prevent the group homes that serve them from being established. A number of cases demonstrate the vehemence with which neighborhoods, zoning boards, and other municipal bodies will fight group homes. However, several courts have found that using zoning to restrict group homes for persons with HIV violates the FHA,[29] often implicating both the discriminatory intent and disparate impact prongs.

While discriminatory intent may be difficult to prove, courts have accepted evidence of intent by examining the context of the decision to create zoning laws. Even where a defendant government agency does not itself express prejudice, intent may be demonstrated by how such an agency reacts to community opposition. In *Ass'n of Relatives and Friends of AIDS Patients v. Regulations and Permits Administration*, for example, the court found that, while most of the hostility and prejudice expressed against an AIDS hospice came from community opposition groups, rather than the permit administration itself, the administration had "acted in furtherance of the misguided and discriminatory notions" of those groups, and had thus implicated the FHA's discriminatory intent prong.[30]

[25] 343 F.3d at 1150 ("[A]ccommodations may adjust for the practical impact of a disability, not only for the immediate manifestations of the physical or mental impairment giving rise to the disability.").
[26] 386 F.3d 1259, 1260 (9th Cir. 2004).
[27] *Id.* at 1260-61.
[28] *Id.* at 1264.
[29] *See, e.g.*, Stewart B. McKinney Found., Inc. v. Town Plan and Zoning Comm'n of Fairfield, 790 F. Supp. 1197, 1214 (D. Conn. 1992) (holding that requiring a special exception to use a two-person home as housing for HIV-positive persons violates the FHA); Support Ministries for Persons with AIDS, Inc. v. Vill. of Waterford, 808 F. Supp. 120, 133 (N.D.N.Y. 1992) (changing zoning laws to exclude a residence for HIV-positive homeless persons violates the FHA); Ass'n of Relatives and Friends of AIDS Patients v. Regulations and Permits Admin., 740 F. Supp. 95, 107 (D. P.R. 1990) (denial of a special use permit to an AIDS hospice violated the FHA); Baxter v. City of Belleville, 720 F. Supp. 720, 733 (S.D. Ill. 1989) (denying special use permit to a group home for homeless persons living with AIDS is a violation of the FHA).
[30] 740 F. Supp. at 104.

Where evidence of discriminatory intent is lacking, courts also have been willing to examine zoning law administration through the disparate impact prong of the FHA. First, courts have recognized that the special needs of persons with disabilities, including people with HIV, make them more likely to require a group environment than those without disabilities.[31] Once this has been established, zoning laws that exclude group homes are more likely to be viewed as disparately affecting people with disabilities. Courts also consider burdensome administrative hurdles often imposed on group homes for people with HIV as evidence that zoning laws are disparately affecting them.[32]

Group homes encountering burdensome zoning-related barriers might also look to the reasonable accommodations prong of the FHA. Even where a court has declined to hold that a zoning ordinance inherently runs afoul of the FHA, failure to exempt a group home from a zoning law may violate the reasonable accommodations prong of the FHA.[33]

b. Covenants

Group homes may be excluded from residential areas not only by zoning laws, but by neighborhoods themselves. Many residential neighborhoods have covenants that restrict the use of land within neighborhood borders through both property law and contract law mechanisms. Often such covenants restrict home occupancy to "single family" use, which can preclude group homes. At least one court has found that such restrictions, when applied to group homes for people living with AIDS, violate the FHA and may also be precluded by other common law protections. In *Hill v. Community of Damien of Molokai*, the court examined a neighborhood's restrictive covenant, which limited occupancy to single family use.[34] The neighborhood attempted to use this covenant to prevent the use of a property as a group home for persons living with AIDS.[35] However, the court found that public policy in favor of integrating people with disabilities into mainstream residential life and common law principals favoring free enjoyment of property meant that the group home, which was designed to provide a "familial" atmosphere, would not violate the covenant.[36] Moreover, the court found that even if the group home could not be considered single family use, attempting to enforce the covenant against it would violate the disparate impact and reasonable accommodations prongs of the FHA.[37] This case and the general trend of zoning cases discussed above indicate that the FHA, as well as common law protections, can help protect the right of people living with HIV to live in group homes in mainstream residential settings.

[31] *See* Hill v. Cmty. of Damien of Molokai, 911 P.2d 861, 873 (N.M. 1996) (some persons with AIDS may require congregate living in order to remain in a residential community); Oxford House, Inc. v. Town of Babylon*,* 819 F. Supp. 1179, 1183 (E.D.N.Y. 1993) (recovering alcoholics need to live in a group home for proper support, so zoning out group homes disparately affects them); *Support Ministries*, 808 F. Supp. at 132 (some persons living with HIV may not be able to live outside a group home).

[32] *See Baxter,* 720 F.Supp. at 732; Stewart B. McKinney Found.*,* 790 F. Supp. at 1219-20.

[33] *See Oxford,* 819 F. Supp. at 1185-6 (noting that even if a town's definition of "family" for the purposes of its zoning laws did not itself violate the FHA by disparately affecting people with disabilities, failure to reasonably accommodate the group home by not applying the definition against it would be a violation).

[34] 911 P.2d 861 (N.M. 1996).

[35] *Id.* at 865.

[36] *Id.* at 866-69.

[37] *Id.* at 873-76.

B. Additional Protections for Women and Transgender Individuals

Women and transgender people living with HIV may face obstacles related to their gender or gender identity that limit their ability to obtain and retain stable housing. Many women living with HIV in the United States are low-income women of color with parental responsibilities.[38] Transgender individuals, a significant proportion of whom are HIV positive,[39] also face housing instability, in part due to the severe stigma surrounding their gender identity.[40] Socioeconomic factors, coupled with sexual harassment and gender-based discrimination, domestic violence, and power imbalances between landlords and low-income tenants, create barriers to safe, affordable housing for women and transgender individuals living with HIV.

Various federal, state, and municipal rules help eliminate gender-based barriers to stable housing. The federal Fair Housing Act (FHA) prohibits housing providers from denying housing and discriminating against a person in the "terms and conditions" of housing on the basis of sex.[41] However, no reported court opinion has interpreted this prohibition to protect transgender individuals from discrimination based on their gender identity.[42] Relying on federal employment law, courts also interpret the FHA to prohibit sexual harassment that conditions housing benefits on sexual favors,[43] or that is frequent and severe enough to create an unreasonably hostile living environment.[44] Because not all sexual harassment is actionable under the FHA, the Act may not adequately protect the interests of women living with HIV who find their living environment unsafe as consequence of sexual harassment but have limited resources with which to obtain alternative housing.[45] HUD's proposed guidelines for sex-based discrimination claims under the FHA could broaden the scope of prohibited harassment; however, the agency has not yet adopted them.[46] Women who have been victims of domestic violence may find relief from courts that interpret the FHA as prohibiting actions that discriminate against victims of domestic violence given that such discrimination disproportionately impacts women.[47] The Violence Against Women Act and HUD's

[38] HENRY J. KAISER FAMILY FOUNDATION, HIV/AIDS POLICY FACT SHEET: WOMEN AND HIV/AIDS IN THE UNITED STATES 1 (2008), *available at* http://www.kff.org/hivaids/upload/6092-061.pdf.
[39] Jeffrey H. Herbst, Elizabeth D. Jacobs, Teresa J. Finlayson, Vel S. McKleroy, Mary Spink Neumann & Nicole Crepaz, *Estimating HIV Prevalence and Risk Behaviors of Transgender Persons in the United States: A Systematic Review*, 12 AIDS BEHAV. 1 (2008).
[40] Daniella Lichtman Esses, *Afraid to Be Myself, Even at Home: A Transgender Cause of Action Under the Fair Housing Act*, 42 COLUM. J.L. & SOC. PROBS. 465, 481-85 (2009).
[41] Fair Housing Act, 42 U.S.C. § 3604(a),(b).
[42] Esses, s*upra* note 40, at 500.
[43] Honce v. Vigil, 1 F.3d 1085, 1089 (10th Cir. 1993) (citing Hicks v. Gates Rubber Co., 833 F.2d 1406, 1413 (10th Cir. 1987).
[44] *See* DiCenso v. Cisneros, 96 F.3d 1004,1008-09 (7th Cir. 1996) (single incident of caressing a tenant's arm and suggesting sex as an alternative to rent is not sufficiently severe or pervasive sexual harassment).
[45] *See Honce*, 1 F.3d at 1094 (Seymour, J. dissenting) (recognizing a single mother's financial difficulty in leaving a housing situation in which offensive conduct has occurred).
[46] Fair Housing Act Regulations Amendments Standards Governing Sexual Harassment Cases, 65 Fed. Reg. 67666, 67667 (proposed Nov. 13, 2000) (to be codified at 24 CFR pt. 100) (unwelcome verbal or intentional touching of any body part may constitute sexual harassment under the FHA); ROBERT G. SCHWEMM, HOUSING DISCRIMINATION: LAW AND LITIGATION § 11C:2 (Supp. 2009).
[47] *See* Bouley v. Young-Sabourin, 394 F.Supp.2d 675, 677, 678 (D. Vt. 2005) (recognizing a prima facie case of sex discrimination where landlord evicted tenant less than 72 hours after the tenant's husband assaulted her); *but cf.* Robinson v. Cincinnati Metro. Hous. Auth., No. 08-CV-238, 2008 WL 1924255 at *3 (S.D. Ohio Apr. 29, 2008) (evicting victims of domestic violence may constitute sex discrimination, but denying a victim's request to transfer to another unit is not).

accompanying regulations affirmatively prohibit housing agents from using a documented incident of domestic or dating violence or stalking to evict or deny housing to victims and their family members who are recipients of Section 8 federal housing assistance.[48] State and local laws are an additional source of housing protection for victims of domestic violence.[49]

The FHA also prohibits housing discrimination the basis of familial status, and may also prohibit housing policies that have a disproportionate impact on families with children.[50] Though this area of housing law remains underdeveloped, it could potentially provide an additional tool to ensure that housing for people living with HIV accommodates the needs of HIV-positive individuals with children, who are disproportionately women.[51]

While federal law provides little protection for transgender individuals seeking stable housing,[52] transgender individuals may find legal remedies in state or municipal law. Twelve states plus the District of Columbia and at least 104 cities or counties have enacted anti-discrimination laws that prohibit housing discrimination against transgender individuals.[53] Several other states have interpreted statutes that prohibit sex discrimination to include gender identity discrimination.[54]

C. International Human Rights Law

1. Using the Human Rights Framework in U.S. Courts

International human rights law can be a useful tool to advocate for the housing rights of people living with HIV/AIDS. This section provides specific background information and guidance on how international human rights law can strengthen domestic protections of the right to housing.

Before discussing substantive international norms, it is first necessary to understand how they can be used. This subsection briefly outlines how these international human rights norms are used by advocates in U.S. courts.

The human rights norms discussed in subsection B below stem from several sources. Several are derived from treaties, also known as "conventions," which the United States has either signed and ratified or has signed without ratifying. Under international law, the United States is bound to

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[48] 42 U.S.C.A. § 1437f(c)(9)(a); U.S. DEP'T OF HOUS. AND URBAN DEV., OFFICE OF HOUS., NOTICE: H08-07, IMPLEMENTATION OF THE VIOLENCE AGAINST WOMEN AND JUSTICE DEPARTMENT REAUTHORIZATION ACT OF 2005 FOR THE MULTIFAMILY PROJECT-BASED SECTION 8 HOUSING ASSISTANCE PAYMENTS PROGRAM (2008), *available at* www.hud.gov/offices/adm/hudclips/notices/hsg/files/08-07HSGN.doc.

[49] NAT'L COALITION AGAINST DOMESTIC VIOLENCE, DOMESTIC VIOLENCE AND HOUSING, *available at* http://www.ncadv.org/files/Housing_.pdf (last visited June 12, 2009).

[50] 42 U.S.C. 3604; *see* Schwemm, *supra* note 46 Doe v. City of Butler, 892 F.2d 315, 323-24 (3d. Cir. 1989) (dwelling occupancy limit may have a discriminatory effect on women with children).

[51] SCHWEMM, *supra* note 46, at § 11E:4.

[52] *See* Esses, s*upra,* note 40. While the ADA protects people from discrimination based on their HIV status, it does not recognize gender-identity-disorder as a disability. 42 U.S.C. § 12211(b).

[53] NATIONAL GAY AND LESBIAN TASK FORCE, SCOPE OF EXPLICITLY TRANSGENDER-INCLUSIVE ANTI-DISCRIMINATION LAWS (2008), *available at* http://www.thetaskforce.org/downloads/reports/fact_sheets/TI_antidisc_laws_7_08.pdf

[54] ACLU, TRANSGENDER PEOPLE AND THE LAW, *available at* http://www.aclu.org/lgbt/transgender/kyr_transgender.html (last visited June 12, 2009).

uphold obligations under the treaties it has ratified. Where the United States has signed but not ratified a treaty, it is obligated not to act contrary to the purpose of the convention under Article 18 of the Vienna Convention on the Law of Treaties.[55] Another source of international law is "customary international law"—norms established by the customs of nations,[56] which may also be reflected in treaties, declarations, and other international agreements. Finally, this section also cites documents that are non-binding in themselves but that interpret binding treaty obligations or customary international law.

The role of these international obligations in U.S. law is complex and often contradictory. Under U.S. law, treaties and customary international law are binding, but do not necessarily give rise to a private right of action. The Constitution declares that treaties are the "supreme Law of the Land"[57] and federal common law has accorded the same status to customary international law.[58] However, it is difficult to bring private causes of action in U.S. courts under international law because of significant procedural obstacles. For example, the United States has declared most treaties "non-self-executing," meaning that ratification in itself does not create a private cause of action under the treaty. Moreover, the United States often ratifies treaties with "reservations" limiting their legal effect and ability to be enforced through private actions in courts. As a result, while the U.S. is bound by the treaties it ratifies and by customary international law, it is difficult to enforce international law in U.S. courts.

However, even without creating a private cause of action, international human rights law may still play a vital role in defending the housing rights of people living with HIV/AIDS. Public interest lawyers have successfully used international human rights treaties and other documents interpreting international human rights law to inform judges' decisions by framing domestic legal issues in a broader international context.[59] Many courts, including the Supreme Court, have been receptive to domestic legal arguments that incorporate international human rights norms as a source of support. The Supreme Court has cited international human rights standards in finding unconstitutional laws prohibiting sodomy,[60] and laws allowing the imposition of the death penalty for juveniles[61] and defendants with mental retardation,[62] and in upholding race-conscious admissions policies in higher education.[63]

The importance of international human rights norms is not limited to treaties that the United States

[55] The Vienna Convention on the Law of Treaties is a separate treaty governing treaty interpretation and adherence that the United States has ratified. Vienna Convention on the Law of Treaties art. 18, May 23, 1969, 1155 U.N.T.S. 331, 336 (entered into force on Jan., 27, 1980); *see also* Jean Koh Peters, *How Children Are Heard in Child Protective Proceedings, in the United States and around the World in 2005: Survey Findings, Initial Observations, and Areas for Further Study*, 6 NEV. L.J. 966, 969 (2006).
[56] U.N. Charter, art. 38, para. 1(b).
[57] U.S. CONST., art. VI, cl. 2.
[58] *See* RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW OF THE UNITED STATES § 102 cmt. j. (1987); *see also* Scott L. Cummings, *The Internationalization of Public Interest Law*, 57 DUKE L. J. 891, 983-84 (2008); *c.f.* Beharry v. Reno, 183 F.Supp.2d 584, 597-601 (E.D.N.Y. 2002) (stating that the Convention on the Rights of the Child is binding on U.S. courts as a source of customary international law), *rev'd on other grounds*, Beharry v. Ashcroft, 329 F.3d 51 (2d Cir. 2003).
[59] *See* Cummings, *supra* note 58, at 985-87.
[60] *See* Lawrence v. Texas, 539 U.S. 558, 573 (2003).
[61] *See* Roper v Simmons, 543 U.S. 551, 575-78 (2005).
[62] *See* Atkins v. Virginia, 536 U.S. 304, 316 n.21 (2002).
[63] *See* Grutter v. Bollinger, 539 U.S. 306, 344 (2003) (Ginsburg, J., concurring).

has ratified. While ratification demonstrates the formal incorporation of an international agreement into U.S. law, courts have also relied upon non-ratified treaties, customary international law, and general state practice in their decisions. For example, in *Roper v. Simmons*, the Supreme Court cited the Convention on the Rights of the Child (CRC), a treaty that the U.S. has not ratified but which is widely acknowledged as customary international law,[64] in determining that the execution of minors is unconstitutional.[65] The Court also looked to the practice of other states in making its determination.[66] At least one federal court in the United States has explicitly cited sections of the CRC as customary international law binding on United States courts.[67] Thus, international human rights norms may be particularly useful for framing issues in the context of international practice where a U.S.-based practice falls out of line with a general international consensus.[68]

2. International Human Rights Norms Protecting the Right to Safe, Stable, and Affordable Housing

International human rights law also supports the right of persons living with HIV/AIDS to safe, stable, and affordable housing free from harassment or intimidation.[69] This right is protected by numerous provisions of international human rights instruments, several of which are outlined below:

Protected Right	International Human Rights Instrument	Corresponding Obligations of the United States
The right to non-discrimination, equal protection, and equality before the law	• Art. 7 of the Universal Declaration of Human Rights ("Universal Declaration")[70] • Art. 3 and Art. 26 of the International Covenant on Civil and Political Rights ("ICCPR")[71] • The Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW")[72] • Art. 5 of the International Convention on the Elimination of All Forms of Racial Discrimination ("ICERD")[73] • The Convention on the Rights of Persons	• The Universal Declaration is non-binding, but is considered customary international law. • The United States has signed and ratified the ICCPR, making it binding on the United States. • The United States has signed but not ratified the CEDAW, and thus has an obligation not to act contrary to the purpose of the convention under Article 18 of the Vienna Convention. • The United States has signed and ratified the ICERD, making it binding

[64] *See, e.g.*, Barbara Atwood, *The Voice of the Indian Child: Strengthening the Indian Child Welfare Act through Children's Participation*, 50 ARIZ. L. REV. 127, 139-40 (2008) (citing the Convention as the "consensus of world opinion regarding children's rights")
[65] 543 U.S. at 575-78.
[66] *See id.*
[67] *See Beharry*, 183 F.Supp.2d at 600-01.
[68] *See* Sarah H. Cleveland, *Our International Constitution*, 31 YALE J. INT'L L. 1, 80 (2006) (noting that international human rights norms are relevant to jurisprudence determining whether a particular form of conduct is "arbitrary and conscience-shocking" or is "implicit in the concept of ordered liberty").
[69] "The Commission on Human Rights has confirmed that 'other status' in non-discrimination provisions is to be interpreted to include health status, including HIV/AIDS." Office of the High Comm'r for Human Rights & Joint U.N. Programme on HIV/ AIDS (UNAIDS), *International Guidelines on HIV/AIDS and Human Rights*, ¶ 108, U.N. Doc. HR/PUB/06/9 (2006) [hereinafter *International Guidelines*]. UNAIDS brings together ten organizations of the United Nations system: the United Nations High Commissioner for Refugees, the United Nations Children's Fund, the United Nations World Food Programme, the United Nations Development Programme, the United Nations Population Fund, the United Nations Office on Drugs and Crime, the International Labour Organization, the United Nations Educational, Scientific, and Cultural Organization, the World Health Organization, and the World Bank.

	with Disabilities ("CRPD")[74]	on the United States. • The United States has signed but not ratified the CRPD, and thus has an obligation not to act contrary to the purpose of the convention under Article 18 of the Vienna Convention.
The right to be free from arbitrary interference with the home	• Art. 12 of the Universal Declaration • Art. 17(1) of the ICCPR • Art. 16(1) of the Convention on the Rights of the Child ("CRC")[75]	• See Universal Declaration above. • See ICCPR above. • The United States has signed but not ratified the CRC, and thus has an obligation not to act contrary to the purpose of the convention under Article 18 of the Vienna Convention.
The right to an adequate standard of living, including housing	• Art. 25(1) of the Universal Declaration • Art. 11(1) of the International Covenant on Economic, Social and Cultural Rights ("ICESCR")[76] • Art. 14(1)(h) of the CEDAW • Art. 5(e)(iii) of the ICERD • Art. 27(3) of the CRC • Art. 28 of the CRPD	• See Universal Declaration above. • The United States has signed but not ratified the ICESCR, and thus has an obligation not to act contrary to the purpose of the convention under Article 18 of the Vienna Convention. • See CEDAW above. • See ICERD above. • See CRC above. • See CRPD above.
The right to privacy	• Art. 12 of the Universal Declaration • Art. 17 of the ICCPR • Art. 16(1) of the CRC	• See Universal Declaration above. • See ICCPR above. • See CRC above.

The U.N. Committee on Economic, Social and Cultural Rights, the purpose of which is to provide authoritative guidance on the provisions of the ICESCR, has adopted a broad view of what constitutes "adequate housing" pursuant to Art. 11(1) of the ICESCR.[77] Specifically, the Committee has noted that the ICESCR includes protection against "forced eviction, harassment and other

[70] Universal Declaration of Human Rights, G.A. Res. 217A, U.N. GAOR 3d Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 12, 1948) [hereinafter Universal Declaration].
[71] International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR].
[72] Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, 1249 U.N.T.S. 13 [hereinafter CEDAW].
[73] International Convention on the Elimination of All Forms of Racial Discrimination, Mar. 7, 1966, 660 U.N.T.S. 195 [hereinafter ICERD].
[74] Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, U.N. Doc. A/61/611 [hereinafter CRPD]. The CRPD notes that, "[p]ersons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others," which would include many persons living with HIV/AIDS. *Id.* at Art. 1.
[75] Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3 [hereinafter CRC].
[76] International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR].
[77] The Committee notes that "adequate housing" includes: legal security of tenure; availability of services, materials, facilities, and infrastructure; affordability; habitability; accessibility; location; and cultural adequacy. U.N. Comm. on Economic, Social and Cultural Rights, General Comment 4: The right to adequate housing (Art. 11(1)), ¶ 8, U.N. Doc. E/1992/23 (Dec. 13, 1991).

threats."[78] For instance, it would violate this right for a landlord to evict a person because of their illness, or to otherwise threaten or harass a person with HIV/AIDS. It would also be contrary to international law's protections against discrimination to refuse to rent or sell a house or apartment to a person with HIV/AIDS, or to refuse to adequately maintain a property because of a person's illness.

The right to adequate housing is also embodied in the International Guidelines on HIV/AIDS and Human Rights ("International Guidelines"), a document put forth by the Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS ("UNAIDS").[79] Although the International Guidelines are not binding law like a ratified treaty, they are a persuasive interpretation of some of the rights embodied in international treaties. In this way, they are useful for putting the treaties into context. The International Guidelines state that the right to adequate housing is an especially important protection for people living with HIV/AIDS in light of their heightened susceptibility to discrimination on the basis of their illness.[80] Because of this, the International Guidelines direct states to enact anti-discrimination laws that cover both the public and private sector, which means they should cover all forms of privately owned and government-funded housing.[81]

A universal commitment to providing adequate housing in a non-discriminatory manner is also embodied in The Habitat Agenda, which is a global plan of action adopted at the second United Nations Conference on Human Settlements (Habitat), held in Istanbul, Turkey in 1996, drafted by the United Nations Human Settlements Programme (UN-HABITAT).[82] Like the International Guidelines, the Habitat Agenda is not binding law, but is a useful and influential source of treaty interpretation. The Habitat Agenda notes that, "[t]he provision of adequate housing for everyone requires action not only by Governments, but by all sectors of society, including the private sector, nongovernmental organizations, communities and local authorities, as well as by partner organizations and entities of the international community."[83] As a subset of the U.N. Economic and Social Council, the work of UN-HABITAT is geared toward improving the living conditions of all U.N. member states, including the United States.

These international instruments and accompanying interpretive documents provide strong support for the argument that international law requires nations to provide a broad range of protections for the right of all peoples, including those who are living with HIV/AIDS, to safe, stable, affordable, and harassment-free housing. As outlined in the chart above, these rights are derived from various international instruments, many of which are binding on the United States, and all of which obligate the United States, at a minimum, not to act in a contrary manner.

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[78] U.N. Comm. on Econ., Soc. and Cultural Rights, General Comment 7: The right to adequate housing (Art. 11(1)): forced evictions, Annex IV ¶ 1, U.N. Doc. E/1998/22 (May 20, 1997).
[79] *See, e.g.*, *International Guidelines*, *supra* note 69, ¶ 102 (echoing many of the rights delineated above).
[80] *See id.* ¶ 147.
[81] *See id.* ¶¶ 9, 22(a).
[82] The United Nations Centre for Human Settlements (Habitat), About UNCHS, http://www.un.org/ga/Istanbul+5/aboutunchs.htm (last visited February 17, 2010). "The United Nations Centre for Human Settlements (Habitat), established in 1978, is the lead agency within the UN system for coordinating activities in the field of human settlements development. It also serves as focal point for monitoring progress on implementation of the Habitat Agenda," *Id.*
[83] UN-HABITAT, The Habitat Agenda Goals and Principles, Commitments and the Global Plan of Action, ¶ 61, *available at* http://www.unchs.org/downloads/docs/1176_6455_The_Habitat_Agenda.pdf.

D. Other Protections

While the FHA is a major avenue of redress for housing discrimination claims, it is not the only legal protection for persons living with HIV. In the context of group home exclusion, both Title II of the Americans with Disabilities Act (ADA),[84] which prohibits discrimination on the basis of disability by public entities, and the Rehabilitation Act,[85] which prohibits discrimination on the basis of disability by recipients of federal funds, may also provide some protection against discriminatory zoning laws. The Third and Sixth Circuits have both found, for example, that "zoning out" methadone clinics violates Title II of the ADA and the Rehabilitation Act.[86] Although individuals with HIV are typically considered by courts to be persons with disabilities under the ADA and the Rehabilitation Act, HIV is not a *per se* disability under either; thus, the plaintiff must demonstrate that he or she has a disability as defined by the ADA or Rehabilitation Act.[87] If this showing can be made, however, the ADA and the Rehabilitation Act can be used to invalidate discriminatory zoning ordinances.

State laws are another source of housing protection for people living with HIV. New York State, for example, prohibits housing discrimination against the people with disabilities through its Human Rights Law,[88] which New York courts have interpreted to apply to people living with HIV.[89] Other states, including New Jersey[90]and California,[91] have similar laws that have been interpreted to protect HIV-positive people. Even where a state's anti-discrimination law has not yet been judicially construed to apply to people with HIV, as in Massachusetts, courts sometimes indicate that such statutes should be interpreted in harmony with the Fair Housing Act and other federal laws[92]; this

[84] 42 U.S.C. § 12101, *et seq.* (2008).
[85] 29 U.S.C. § 701, *et seq.* (2008).
[86] *See* New Directions Treatment Servs. v. City of Reading, 490 F.3d 293, 305 (3d Cir. 2007) (a zoning ordinance that excluded methadone clinics from the city violated the ADA and the Rehabilitation Act, and the ADA's reasonable accommodation provision did not apply where an ordinance was facially discriminatory); MX Group, Inc. v. City of Covington, 293 F.3d 326, 344-45 (6th Cir. 2002) (same). Similarly, in *Bay Area Addiction Research and Treatment, Inc. v. City of Antioch*, 179 F.3d 725 (9th Cir. 1999), the Ninth Circuit held that a zoning ordinance that excluded methadone clinics was facially discriminatory under the ADA and Rehabilitation Act, and that the reasonable accommodation provision was inapplicable to a facially discriminatory law. The court remanded the case for a determination of whether methadone clinic patients fell under the "significant risk" exception, unlike the Third and Sixth Circuit, which found that the methadone clinic posed no significant risk. *See id.* at 737. However, the court's language warned against relying on stereotypes, prejudices, and unfounded fears in making this determination. *See id.* at 736-37.
[87] In *Bragdon v. Abbott* the Supreme Court addressed when HIV infection would be a disability under the ADA. The court held that HIV could be considered "an impairment from the moment of infection," but must also substantially limit a major life activity to trigger the statute's protections. 524 U.S. 624, 637 (1998). The court held that the respondent's HIV-positive status was a physical impairment that substantially limited a major life activity, but declined to find that HIV was a *per se* disability under the ADA. *Id.* at 641-2.
[88] N.Y. EXEC. LAW § 296 (McKinney 2008).
[89] *See, e.g.* Petri v. Bank of N.Y. Co., Inc., 58 N.Y.S.2d 608, 611-12 (N.Y. Sup. Ct. 1992) (asymptomatic HIV is a disability under § 296).
[90] *See, e.g.* N.J. STAT. ANN. § 10:5-1, *et seq* (2008)*;* Poff v. Caro, 549 A.2d 900, 903 (N.J. Super. Ct. Law Div. 1987) (AIDS is a disability protected by the Law Against Discrimination).
[91] *See* CAL. GOV'T CODE § 12955 (2008) (making housing discrimination against people with disabilities unlawful); CAL. GOV'T CODE § 12926.1(c) (2008) (HIV/AIDS are disabilities under the law).
[92] *See, e.g.*, MASS. GEN. LAWS ANN. ch. 151B § 4(6) (2008) (making housing discrimination against the handicapped unlawful); Commonwealth v. Dowd, 638 N.E.2d 923, 925 (Mass. App. Ct. 1994) (Fair Housing Act is statutory prototype for state antidiscrimination law); Cox v. New England Tel. and Tel. Co., 607 N.E.2d 1035, 1039 (Mass. 1993) (Rehabilitation Act case law should guide interpretation of antidiscrimination statute).

suggests that the HIV-positive are included in the state law's protections. Other states, like Texas,[93] simply define disability in language similar or identical to the federal antidiscrimination statutes, which may indicate that courts are willing to interpret them to include HIV, at least to the extent those courts include HIV within the relevant federal law ambit. Some jurisdictions, including Florida[94] and Missouri,[95] may even specifically protect people with HIV from housing discrimination.

Municipal codes are another source of housing protections. New York City's charter, for example, has been interpreted to make housing discrimination against those living with HIV illegal.[96] Other cities, including Washington, D.C.[97] and West Hollywood,[98] have similar ordinances and codes, which may either have been interpreted to apply to people with HIV or explicitly provide protection for them. While the FHA remains the major avenue to vindicate housing rights for the HIV-positive, state law and municipal codes can also provide a source of protection.

III. Housing Assistance

A. Housing Opportunities for Persons with AIDS

1. Overview

While people living with HIV often face adversity in the form of housing discrimination and prejudice, they may have access to housing programs that can help them secure and remain in safe, affordable housing. The largest federal program for people living with HIV is Housing Opportunities for Persons with AIDS (HOPWA).[99] Eligible persons under HOPWA include people with "acquired immunodeficiency syndrome or a related disease."[100] HUD implementing regulations have included HIV infection as a related disease,[101] which means that a person need not be diagnosed with AIDS to be eligible for HOPWA funding. Recipients of HOPWA funding must also be low-income, which is defined as below 80% of the area median income.[102] HOPWA is allocated

[93] TEX. PROP. CODE ANN. § 301.003(6) (2007) (defining "disability" for the purpose of the Texas Fair Housing Act with language identical to that of the ADA, but with explicit exceptions, such as sexual orientation, not applicable here).
[94] FLA. STAT. ANN. § 760.50(4)a (2008) ("A person may not discriminate against an otherwise qualified individual in housing, public accommodations, or governmental services on the basis of the fact that such individual is, or is regarded as being, infected with human immunodeficiency virus.").
[95] *See e.g.* MO. ANN. STAT. § 213.040 (2008) (making housing discrimination against people with disabilities unlawful); MO. ANN. STAT. § 191.665 (2008) (the provisions of § 213.040 cover people with HIV).
[96] *See e.g.* N.Y.C. ADMIN CODE § 8-107(5) (2008); Barton v. N.Y.C. Comm'n on Human Rights, 531 N.Y.S.2d 979, 983 (N.Y. Sup. Ct. 1988) (people with AIDS are disabled under the New York City Administrative Code).
[97] *See e.g.* D.C. CODE § 2-1402.21(a) (2008) (making housing discrimination against people with disabilities unlawful); Joel Truitt Management, Inc. v. Dist. of Columbia Comm'n of Human Rights, 646 A.2d 1007, 1009 (D.C. 1994) (People living with AIDS are protected by the Code).
[98] *See e.g.* WEST HOLLYWOOD MUN. CODE § 9.40.040 (1985) (prohibiting housing discrimination for people with HIV); Jasperson v. Jessica's Nail Clinic, 265 Cal. Rptr. 301 (Cal. Ct. App. 1989).
[99] 42 U.S.C. § 12901 *et seq.* (2008).
[100] *Id.* § 12902(12).
[101] 24 C.F.R. § 574.3 (2008).
[102] 42 U.S.C. § 12901(3).

to cities and states through a grant formula that weights both an area's population and its AIDS rate. These grantees then allocate funding within their areas to both state and non-state agencies.[103]

Obtaining HOPWA funding may pose a problem for people living with HIV insofar as it requires disclosure of their status to a governmental or other agency. HOPWA's statutory authorization attempts to remedy this by providing that all recipients of funds (both the initial state and city grantees and the agencies that they subsequently grant to) keep the names of all individual HOPWA recipients confidential.[104] However, this right to confidentiality may be difficult for grantees and individuals to enforce. At least one court has found that while a state body's demand for unrestricted access to HOPWA patient files would violate the beneficiaries' constitutional privacy rights, as well as the statutorily created privacy rights, HOPWA does not allow for a private right of action to remedy the violation.[105] The court also denied a remedy on the constitutional violation.[106] There is nothing to suggest that violations of HOPWA's confidentiality clauses are common, but they are possible and may be difficult for individuals to remedy if and when they occur.

While HOPWA benefits may be terminated for violating program requirements or conditions of occupancy, regulations require that assistance be terminated "only in the most severe cases."[107] Before this is done, programs must provide a due process procedure that includes, at minimum, an initial written notice of termination, opportunity for review, and a written notice of a final decision.[108]

HOPWA funding can be used for a variety of activities related to housing, ranging from providing assistance for housing searches,[109] to case management.[110] Most important, HOPWA can provide financing for the housing itself. It does so primarily through the programs detailed below.

2. Rental Subsidies

Under HOPWA, people living with HIV who are income eligible can receive a rental subsidy,[111] which covers the difference between the rent standard or reasonable rent and the expected client contribution, which is either 30% of adjusted monthly income or 10% of gross income.[112] HOPWA rental assistance is an important means by which safe, healthy housing for people with HIV can be assured.

[103] For information on where and how HOPWA funding is distributed in your state, see website of U.S. Dept. of Hous. and Urban Dev. (visited Aug. 7, 2008) http://www.hud.gov/offices/cpd/aidshousing/local/index.cfm.
[104] 42 U.S.C. § 12905(e).
[105] *See* Idaho AIDS Found., Inc. v. Idaho Hous. & Fin. Ass'n, 422 F. Supp.2d 1193, 1200-02 (D. Idaho 2006).
[106] *Id.* at 1200, 1202.
[107] 24 C.F.R. § 574.310(e)(2) (2008).
[108] *Id.*
[109] 42 U.S.C. § 12906(1) (2008).
[110] *Id.* § 12907(b)(6).
[111] *Id.* § 12908.
[112] 24 C.F.R. § 574.310(d) (2008).

3. Short Term Supported Housing

People living with HIV are often at increased risk of homelessness,[113] which is why HOPWA includes funding for Short Term Supported Housing. This funding is used to provide temporary (no more than 60 days in any 6 month period)[114] shelter for homeless persons living with HIV. While the Short Term Supported Housing itself is temporary, the program is meant to help transition clients into permanent housing, including transfer into other HOPWA funded programs.[115]

4. Short Term Rent, Mortgage, and Utility Assistance

For people living with HIV who are currently housed but at risk for homelessness, HOPWA also administers Short Term Rent, Mortgage and Utility (STRMU) Assistance. STRUMU assistance is meant to be a short-term intervention that can cover rent, mortgage and utility payments in order to prevent homelessness and increase housing stability among people living with HIV.[116]

5. Permanent Housing Placement Services

In addition to actually providing housing and subsidizing housing costs, HOPWA funding is also used to provide placement services. These placement services can include housing referrals and tenant counseling, as well as costs associated with housing placement, such as security deposits, first month's rent, application fees, and credit checks.[117]

B. Other Housing Programs

People living with HIV may also be eligible for other HUD housing programs, depending on income and other factors, including current living situation (e.g., homelessness or risk thereof). For example, HUD administers Shelter Plus Care (S+C), which is a rental assistance program for the disabled homeless—including persons with HIV—that includes supportive services.[118] Homeless persons with HIV might also be indirectly eligible for money coming from HUD's Supportive Housing Program, which funds public entities and non-profits in their provision of housing services to the homeless.[119]

Homelessness or risk of homelessness is not a requirement for all HUD assistance. Housing programs also exist for low-income populations, including Section 8 Rental Assistance and the HOME Program. Section 8 Rental Assistance,[120] for example, provides rental subsidies similar to

[113] The homeless population has a median prevalence rate of HIV three times higher than that of the general population. *See* AIDS HOUSING OF WASHINGTON, HOMELESSNESS AND HIV: AHW FACT SHEET 1 (2003).
[114] 24 C.F.R. § 574.330(a) (2008).
[115] OFFICE OF HIV/AIDS HOUSING, U.S. DEPT. OF HOUSING AND URBAN DEVELOPMENT, SHORT TERM SUPPORTED HOUSING 1.
[116] OFFICE OF HIV/AIDS HOUSING, U.S. DEPT. OF HOUSING AND URBAN DEVELOPMENT, SHORT TERM RENT, MORTGAGE, AND UTILITY (STRMU) ASSISTANCE 1.
[117] OFFICE OF HIV/AIDS HOUSING, U.S. DEPT. OF HOUSING AND URBAN DEVELOPMENT, Permanent Housing Placement Services 1.
[118] 42 U.S.C. § 11403 (2008).
[119] OFFICE OF COMMUNITY PLANNING AND DEVELOPMENT, U.S. DEPT. OF HOUSING AND URBAN DEVELOPMENT, FEDERAL HOUSING PROGRAMS FOR PERSONS WITH HIV/AIDS 2 (2001).
[120] *See* 42 U.S.C. § 1437f (2008) (authorizing establishment of rental assistance programs).

those provided by HOPWA.[121] The HOME Program is a flexible, community-based resource that, depending on local decision-making, can provide housing services including tenant-based rental assistance like that of Section 8 and HOPWA.[122] Both Section 8 and the HOME Program may also, in certain localities, establish preferences in granting assistance for people living with HIV.[123]

People living with HIV also benefit from HUD programs designed to help those with disabilities, including the Supportive Housing for Persons with Disabilities Program (Section 811), which provides capital advances and rental assistance to grantees in order to expand the supply of low-income housing for people with disabilities.[124] Section 811 projects must include supportive services that encourage "optimal independent living and participation in normal daily activities."[125] Elderly persons living with HIV might also benefit from the Supportive Housing for the Elderly Program (Section 202), which, in part, provides rental assistance to low-income people over the age of 62.[126]

There may also be limited opportunities for housing assistance funded through the Ryan White HIV/AIDS Treatment Modernization Act of 2006.[127] The main purpose of this Act and the programs promulgated under it is to "ensure that eligible HIV-infected persons and families gain or maintain access to medical care."[128] Because there is a nexus between stable, safe housing and receiving medical care,[129] agency policy indicates that some funds may be used for certain housing services. Housing referral services may be covered, as well as short term/emergency housing that is connected to access to medical care, supportive housing services, and non-supportive housing services that are necessary to HIV medical treatment.[130] Ryan White Funds are a payer of last resort, however, and any housing funding it provides must be supplemental to other federal housing funds.[131]

C. Effect of Criminal Convictions on Public Housing

Despite the many programs ostensibly available to them, people living with HIV who have criminal histories, particularly those involving drug-related offenses,[132] may still be excluded from public housing and other federal housing assistance programs, including Section 8. Housing denials may be

[121] *See* 24 C.F.R. § 982.1 *et seq.* (2008).
[122] *See Id.* § 92.209 *et seq.*
[123] FEDERAL HOUSING PROGRAMS FOR PERSONS WITH HIV/AIDS, supra note 119 at 2.
[124] *Id.* at 2.
[125] *See* 42 U.S.C. § 8013(c)(2) (2008).
[126] *See* 12 U.S.C. § 1701q (2008).
[127] Pub. L. No. 109-415, 120 Stat. 2767 (codified at 42 U.S.C. § 300ff *et seq.* (2008)).
[128] DEPARTMENT OF HEALTH AND HUMAN SERVICES, HAB POLICY NOTICE 08-01, THE USE OF RYAN WHITE HIV/AIDS PROGRAM FUNDS FOR HOUSING REFERRAL SERVICES AND SHORT TERM OR EMERGENCY HOUSING NEEDS (2008).
[129] Indeed, housing is a critical component of the ongoing health, safety and welfare of persons living with HIV/AIDS. *See* HUDSON PLANNING GROUP, AN ASSESSMENT OF THE HOUSING NEEDS OF PERSONS WITH HIV/AIDS, NEW YORK CITY ELIGIBLE METROPOLITAN STATISTICAL AREA 41-44 (2004).
[130] HAB POLICY NOTICE 08-01, *supra* note 128.
[131] *Id.*
[132] This is of particular concern for people living with HIV because of the connection between HIV and drug use. According to the CDC, approximately 19% of women and 12% of men who were infected with HIV in 2006 were infected via injection drug use. CDC, HIV/AIDS IN THE UNITED STATES (2008), *available at* http://www.cdc.gov/hiv/resources/factsheets/us.htm.

based on criteria that require an outright ban, or those that allow housing authorities some discretion in determining whether or not to offer housing assistance.

There are two instances in which housing authorities *must* deny housing: (1) when households include a member who has been convicted of producing methamphetamine on the premises of a federally funded housing program,[133] or (2) when a household member is subject to lifetime registration as a sex offender by a state.[134]

In addition to these mandatory denials, federal law grants discretion to public housing authorities to deny other applicants on the basis of drug-related criminal activity. Tenants who have been evicted from public housing as a result of drug-related criminal activity may be deemed ineligible for public housing for up to three years from the date of the eviction,[135] though the period may be shortened or waived by the agency. Current illegal drug use may also be a basis for denying admission to housing programs, as may a determination that there is reasonable cause to believe that a household member's drug or alcohol use "may interfere with the health, safety, or right to peaceful enjoyment of the premises by other residents."[136] A person may also be turned away from public housing for having engaged in any drug related or other criminal activity during a "reasonable time" before that person sought admission to the housing program.[137] These laws may prevent people living with HIV from obtaining public housing, even if they would otherwise be entitled to it.

IV. Conclusion

People living with HIV need safe, healthy, and affordable housing. Unfortunately, discrimination, disability, and poverty often interfere. There are a range of federal laws and programs, however, that help people living with HIV overcome the barriers they encounter. These tools, along with state and local law protections, and well-informed advocates,[138] all help ensure that all people living with HIV obtain the housing they need and deserve.

[133] 42 U.S.C. § 1437n(f) (2008); 24 C.F.R. §960.204(a)(3). *See also* 24 C.F.R. §§ 882.518(a)(1)(ii), 982.553(a)(1)(ii)(C) (2008) (related to Section 8 programs).
[134] 42 U.S.C. § 13663(a); 24 C.F.R. § 960.204(a)(4). *See also* 24 C.F.R. §§ 882.518(a)(2), 982.553(a)(2)(i) (related to Section 8 programs).
[135] 42 U.S.C. § 13661; 24 C.F.R. § 960.204(a)(1)-(2).
[136] *Id.* § 13661(b)(1)B).
[137] *Id.* § 13661(c).
[138] Housing resources for people living with AIDS include: AIDS Housing Washington (Visted Aug. 7, 2008) http://www.aidshousing.org; Housing Works (Visted Aug. 7, 2008); http://www.housingworks.org; AIDS Housing Alliance SF (Visted Aug. 7, 2008) http://www.ahasf.org; AIDS Housing Corporation (Visted Aug. 7, 2008) http://www.ahc.org.

U.S. Department of Justice
Civil Rights Division
Disability Rights Section

A Guide to Disability Rights Laws

September 2005

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For persons with disabilities, this document is available in large print, Braille, audio tape, and computer disk.

Reproduction of this document is encouraged.

This guide provides an overview of Federal civil rights laws that ensure equal opportunity for people with disabilities. To find out more about how these laws may apply to you, contact the agencies and organizations listed below.

Americans with Disabilities Act (ADA)

The ADA prohibits discrimination on the basis of disability in employment, State and local government, public accommodations, commercial facilities, transportation, and telecommunications. It also applies to the United States Congress.

To be protected by the ADA, one must have a disability or have a relationship or association with an individual with a disability. An individual with a disability is defined by the ADA as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment. The ADA does not specifically name all of the impairments that are covered.

ADA Title I: Employment

Title I requires employers with 15 or more employees to provide qualified individuals with disabilities an equal opportunity to benefit from the full range of employment-related opportunities available to others. For example, it prohibits discrimination in recruitment, hiring, promotions, training, pay, social activities, and other privileges of employment. It restricts questions that can be asked about an applicant's disability before a job offer is made, and it requires that employers make reasonable accommodation to the known physical or mental limitations of otherwise qualified individuals with disabilities, unless it results in undue hardship. Religious entities with 15 or more employees are covered under title I.

Title I complaints must be filed with the U. S. Equal Employment Opportunity Commission (EEOC) within 180 days of the date of discrimination, or 300 days if the charge is filed with a designated State or local fair employment practice agency. Individuals may file a lawsuit in Federal court only after they receive a "right-to-sue" letter from the EEOC.

Charges of employment discrimination on the basis of disability may be filed at any U.S. Equal

Employment Opportunity Commission field office. Field offices are located in 50 cities throughout the U.S. and are listed in most telephone directories under "U.S. Government." For the appropriate EEOC field office in your geographic area, contact:

(800) 669-4000 (voice)
(800) 669-6820 (TTY)

www.eeoc.gov

Publications and information on EEOC-enforced laws may be obtained by calling:

(800) 669-3362 (voice)
(800) 800-3302 (TTY)

For information on how to accommodate a specific individual with a disability, contact the Job Accommodation Network at:

(800) 526-7234 (voice/TTY)

www.jan.wvu.edu

ADA Title II: State and Local Government Activities

Title II covers all activities of State and local governments regardless of the government entity's size or receipt of Federal funding. Title II requires that State and local governments give people with disabilities an equal opportunity to benefit from all of their programs, services, and activities (e.g. public education, employment, transportation, recreation, health care, social services, courts, voting, and town meetings).

State and local governments are required to follow specific architectural standards in the new construction and alteration of their buildings. They also must relocate programs or otherwise provide access in inaccessible older buildings, and communicate effectively with people who have hearing, vision, or speech disabilities. Public entities are not required to take actions that would result in undue financial and administrative burdens. They are required to make reasonable modifications to policies, practices, and procedures where necessary to avoid discrimination, unless they can demonstrate that doing so would fundamentally alter the nature of the service, program, or activity being provided.

Complaints of title II violations may be filed with the Department of Justice within 180 days of the date of discrimination. In certain situations, cases may be referred to a mediation program sponsored by the Department. The Department may bring a lawsuit where it has investigated a matter and has been unable to resolve violations. For more information, contact:

U.S. Department of Justice
Civil Rights Division
950 Pennsylvania Avenue, N.W.
Disability Rights Section - NYAV
Washington, D.C. 20530

www.ada.gov

(800) 514-0301 (voice)
(800) 514-0383 (TTY)

Title II may also be enforced through private lawsuits in Federal court. It is not necessary to file a complaint with the Department of Justice (DOJ) or any other Federal agency, or to receive a "right-to-sue" letter, before going to court.

ADA Title II: Public Transportation

The transportation provisions of title II cover public transportation services, such as city buses and public rail transit (e.g. subways, commuter rails, Amtrak). Public transportation authorities may not discriminate against people with disabilities in the provision of their services. They must comply with requirements for accessibility in newly purchased vehicles, make good faith efforts to purchase or lease accessible used buses, remanufacture buses in an accessible manner, and, unless it would result in an undue burden, provide paratransit where they operate fixed-route bus or rail systems. Paratransit is a service where individuals who are unable to use the regular transit system independently (because of a physical or mental impairment) are picked up and dropped off at their destinations. Questions and complaints about public transportation should be directed to:

Office of Civil Rights
Federal Transit Administration
U.S. Department of Transportation
400 Seventh Street, S.W.
Room 9102
Washington, D.C. 20590

www.fta.dot.gov/ada

(888) 446-4511 (voice/relay)

ADA Title III: Public Accommodations

Title III covers businesses and nonprofit service providers that are public accommodations, privately operated entities offering certain types of courses and examinations, privately operated transportation, and commercial facilities. Public accommodations are private entities who own, lease, lease to, or operate facilities such as restaurants, retail stores, hotels, movie theaters, private schools, convention centers, doctors' offices, homeless shelters, transportation depots, zoos, funeral homes, day care centers, and recreation facilities including sports stadiums and fitness clubs. Transportation services provided by private entities are also covered by title III.

Public accommodations must comply with basic nondiscrimination requirements that prohibit exclusion, segregation, and unequal treatment. They also must comply with specific requirements related to architectural standards for new and altered buildings; reasonable modifications to policies, practices, and procedures; effective communication with people with hearing, vision, or speech disabilities; and other access requirements. Additionally, public accommodations must remove barriers in existing buildings where it is easy to do so without much difficulty or expense, given the public accommodation's resources.

Courses and examinations related to professional, educational, or trade-related applications, licensing, certifications, or credentialing must be provided in a place and manner accessible to people with disabilities, or alternative accessible arrangements must be offered.

Commercial facilities, such as factories and warehouses, must comply with the ADA's architectural standards for new construction and alterations.

Complaints of title III violations may be filed with the Department of Justice. In certain situations, cases may be referred to a mediation program sponsored by the Department. The Department is authorized to bring a lawsuit where there is a pattern or practice of discrimination in violation of title III, or where an act of discrimination raises an issue of general public importance. Title III may also be enforced through private lawsuits. It is not necessary to file a complaint with the Department of Justice (or any Federal agency), or to receive a "right-to-sue" letter, before going to court. For more information, contact:

U.S. Department of Justice
Civil Rights Division
950 Pennsylvania Avenue, N.W.
Disability Rights Section - NYAV
Washington, D.C. 20530

www.ada.gov

(800) 514-0301 (voice)
(800) 514-0383 (TTY)

ADA Title IV: Telecommunications Relay Services

Title IV addresses telephone and television access for people with hearing and speech disabilities. It requires common carriers (telephone companies) to establish interstate and intrastate telecommunications relay services (TRS) 24 hours a day, 7 days a week. TRS enables callers with hearing and speech disabilities who use telecommunications devices for the deaf (TDDs), which are also known as teletypewriters (TTYs), and callers who use voice telephones to communicate with each other through a third party communications assistant. The Federal Communications Commission (FCC) has set minimum standards for TRS services. Title IV also requires closed captioning of Federally funded public service announcements. For more information about TRS, contact the FCC at:

Federal Communications Commission
445 12th Street, S.W.
Washington, D.C. 20554

www.fcc.gov/cgb/dro

(888) 225-5322 (Voice)
(888) 835-5322 (TTY)

Telecommunications Act

Section 255 and Section 251(a)(2) of the Communications Act of 1934, as amended by the Telecommunications Act of 1996, require manufacturers of telecommunications equipment and providers of telecommunications services to ensure that such equipment and services are accessible to and usable by persons with disabilities, if readily achievable. These amendments ensure that people with disabilities will have access to a broad range of products and services such as telephones, cell phones, pagers, call-waiting, and operator services, that were often

inaccessible to many users with disabilities. For more information, contact:

Federal Communications Commission
445 12th Street, S.W.
Washington, D.C. 20554

www.fcc.gov/cgb/dro

(888) 225-5322 (Voice)
(888) 835-5322 (TTY)

Fair Housing Act

The Fair Housing Act, as amended in 1988, prohibits housing discrimination on the basis of race, color, religion, sex, disability, familial status, and national origin. Its coverage includes private housing, housing that receives Federal financial assistance, and State and local government housing. It is unlawful to discriminate in any aspect of selling or renting housing or to deny a dwelling to a buyer or renter because of the disability of that individual, an individual associated with the buyer or renter, or an individual who intends to live in the residence. Other covered activities include, for example, financing, zoning practices, new construction design, and advertising.

The Fair Housing Act requires owners of housing facilities to make reasonable exceptions in their policies and operations to afford people with disabilities equal housing opportunities. For example, a landlord with a "no pets" policy may be required to grant an exception to this rule and allow an individual who is blind to keep a guide dog in the residence. The Fair Housing Act also requires landlords to allow tenants with disabilities to make reasonable access-related modifications to their private living space, as well as to common use spaces. (The landlord is not required to pay for the changes.) The Act further requires that new multifamily housing with four or more units be designed and built to allow access for persons with disabilities. This includes accessible common use areas, doors that are wide enough for wheelchairs, kitchens and bathrooms that allow a person using a wheelchair to maneuver, and other adaptable features within the units.

Complaints of Fair Housing Act violations may be filed with the U.S. Department of Housing and Urban Development. For more information or to file a complaint, contact:

Office of Program Compliance and Disability Rights
Office of Fair Housing and Equal Opportunity
U.S. Department of Housing and Urban Development
451 7th Street, S.W. , Room 5242
Washington, D.C. 20410

www.hud.gov/offices/fheo

(800) 669-9777 (voice)
(800) 927-9275 (TTY)

For questions about the accessibility provisions of the Fair Housing Act, contact Fair Housing FIRST at:

www.fairhousingfirst.org

(888) 341-7781 (voice/TTY)

For publications, you may call the Housing and Urban Development Customer Service Center at:

(800) 767-7468 (voice/relay)

Additionally, the Department of Justice can file cases involving a pattern or practice of discrimination. The Fair Housing Act may also be enforced through private lawsuits.

Air Carrier Access Act

The Air Carrier Access Act prohibits discrimination in air transportation by domestic and foreign air carriers against qualified individuals with physical or mental impairments. It applies only to air carriers that provide regularly scheduled services for hire to the public. Requirements address a wide range of issues including boarding assistance and certain accessibility features in newly built aircraft and new or altered airport facilities. People may enforce rights under the Air Carrier Access Act by filing a complaint with the U.S. Department of Transportation, or by bringing a lawsuit in Federal court. For more information or to file a complaint, contact:

Aviation Consumer Protection Division
U.S. Department of Transportation
400 Seventh Street, S.W.
Room 4107, C-75
Washington, D.C. 20590

airconsumer.ost.dot.gov

(202) 366-2220 (voice)
(202) 366-0511 (TTY)

(800) 778-4838 (voice)
(800) 455-9880 (TTY)

Voting Accessibility for the Elderly and Handicapped Act

The Voting Accessibility for the Elderly and Handicapped Act of 1984 generally requires polling places across the United States to be physically accessible to people with disabilities for federal elections. Where no accessible location is available to serve as a polling place, a political subdivision must provide an alternate means of casting a ballot on the day of the election. This law also requires states to make available registration and voting aids for disabled and elderly voters, including information by telecommunications devices for the deaf (TDDs) which are also known as teletypewriters (TTYs). For more information, contact:

U.S. Department of Justice
Civil Rights Division
950 Pennsylvania Avenue, N.W.
Voting Section - 1800 G
Washington, D.C. 20530

(800) 253-3931 (voice/TTY)

National Voter Registration Act

The National Voter Registration Act of 1993, also known as the "Motor Voter Act," makes it easier for all Americans to exercise their fundamental right to vote. One of the basic purposes of the Act is to increase the historically low registration rates of minorities and persons with disabilities that have resulted from discrimination. The Motor Voter Act requires all offices of State-funded programs that are primarily engaged in providing services to persons with disabilities to provide all program applicants with voter registration forms, to assist them in completing the forms, and to transmit completed forms to the appropriate State official. For more information, contact:

U.S. Department of Justice
Civil Rights Division
950 Pennsylvania Avenue, N.W.
Voting Section - 1800 G
Washington, D.C. 20530

www.usdoj.gov/crt/voting

(800) 253-3931 (voice/TTY)

Civil Rights of Institutionalized Persons Act

The Civil Rights of Institutionalized Persons Act (CRIPA) authorizes the U.S. Attorney General to investigate conditions of confinement at State and local government institutions such as prisons, jails, pretrial detention centers, juvenile correctional facilities, publicly operated nursing homes, and institutions for people with psychiatric or developmental disabilities. Its purpose is to allow the Attorney General to uncover and correct widespread deficiencies that seriously jeopardize the health and safety of residents of institutions. The Attorney General does not have authority under CRIPA to investigate isolated incidents or to represent individual institutionalized persons.

The Attorney General may initiate civil law suits where there is reasonable cause to believe that conditions are "egregious or flagrant," that they are subjecting residents to "grievous harm," and that they are part of a "pattern or practice" of resistance to residents' full enjoyment of constitutional or Federal rights, including title II of the ADA and section 504 of the Rehabilitation Act. For more information or to bring a matter to the Department of Justice's attention, contact:

U.S. Department of Justice
Civil Rights Division
950 Pennsylvania Avenue, N.W.
Special Litigation Section - PHB
Washington, D.C. 20530

www.usdoj.gov/crt/split

(877) 218-5228 (voice/TTY)

Individuals with Disabilities Education Act

The Individuals with Disabilities Education Act (IDEA) (formerly called P.L. 94-142 or the Education for all Handicapped Children Act of 1975) requires public schools to make available to all eligible children with disabilities a free appropriate public education in the least restrictive environment appropriate to their individual needs.

IDEA requires public school systems to develop appropriate Individualized Education Programs (IEP's) for each child. The specific special education and related services outlined in each IEP reflect the individualized needs of each student.

IDEA also mandates that particular procedures be followed in the development of the IEP. Each student's IEP must be developed by a team of knowledgeable persons and must be at least reviewed annually. The team includes the child's teacher; the parents, subject to certain limited exceptions; the child, if determined appropriate; an agency representative who is qualified to provide or supervise the provision of special education; and other individuals at the parents' or agency's discretion.

If parents disagree with the proposed IEP, they can request a due process hearing and a review from the State educational agency if applicable in that state. They also can appeal the State agency's decision to State or Federal court. For more information, contact:

Office of Special Education and Rehabilitative Services
U.S. Department of Education
400 Maryland Avenue, S.W.
Washington, D.C. 20202-7100

www.ed.gov/about/offices/list/osers/osep

(202) 245-7468 (voice/TTY)

Rehabilitation Act

The Rehabilitation Act prohibits discrimination on the basis of disability in programs conducted by Federal agencies, in programs receiving Federal financial assistance, in Federal employment, and in the employment practices of Federal contractors. The standards for determining employment discrimination under the Rehabilitation Act are the same as those used in title I of the Americans with Disabilities Act.

Section 501

Section 501 requires affirmative action and nondiscrimination in employment by Federal agencies of the executive branch. To obtain more information or to file a complaint, employees should contact their agency's Equal Employment Opportunity Office.

Section 503

Section 503 requires affirmative action and prohibits employment discrimination by Federal government contractors and subcontractors with contracts of more than $10,000. For more information on section 503, contact:

Office of Federal Contract Compliance Programs
U.S. Department of Labor
200 Constitution Avenue, N.W.
Room C-3325
Washington, D.C. 20210

www.dol.gov/esa/ofccp

(202) 693-0106 (voice/relay)

Section 504

Section 504 states that "no qualified individual with a disability in the United States shall be excluded from, denied the benefits of, or be subjected to discrimination under" any program or activity that either receives Federal financial assistance or is conducted by any Executive agency or the United States Postal Service.

Each Federal agency has its own set of section 504 regulations that apply to its own programs. Agencies that provide Federal financial assistance also have section 504 regulations covering entities that receive Federal aid. Requirements common to these regulations include reasonable accommodation for employees with disabilities; program accessibility; effective communication with people who have hearing or vision disabilities; and accessible new construction and alterations. Each agency is responsible for enforcing its own regulations. Section 504 may also be enforced through private lawsuits. It is not necessary to file a complaint with a Federal agency or to receive a "right-to-sue" letter before going to court.

For information on how to file 504 complaints with the appropriate agency, contact:

U.S. Department of Justice
Civil Rights Division
950 Pennsylvania Avenue, N.W.
Disability Rights Section - NYAV
Washington, D.C. 20530

www.ada.gov

(800) 514-0301 (voice)
(800) 514-0383 (TTY)

Section 508

Section 508 establishes requirements for electronic and information technology developed, maintained, procured, or used by the Federal government. Section 508 requires Federal electronic and information technology to be accessible to people with disabilities, including employees and members of the public.

An accessible information technology system is one that can be operated in a variety of ways and does not rely on a single sense or ability of the user. For example, a system that provides output only in visual format may not be accessible to people with visual impairments and a system that provides output only in audio format may not be accessible to people who are deaf or hard of hearing. Some individuals with disabilities may need accessibility-related software or peripheral devices in order to use systems that comply with Section 508. For more information on section 508, contact:

U.S. General Services Administration

Center for IT Accommodation (CITA)
1800 F Street, N.W.
Room 1234, MC:MKC
Washington, DC 20405-0001

www.gsa.gov/section508

(202) 501-4906 (voice)
(202) 501-2010 (TTY)

U.S. Architectural and Transportation Barriers Compliance Board
1331 F Street, N.W., Suite 1000
Washington, DC 20004-1111

www.access-board.gov

800-872-2253 (voice)
800-993-2822 (TTY)

Architectural Barriers Act

The Architectural Barriers Act (ABA) requires that buildings and facilities that are designed, constructed, or altered with Federal funds, or leased by a Federal agency, comply with Federal standards for physical accessibility. ABA requirements are limited to architectural standards in new and altered buildings and in newly leased facilities. They do not address the activities conducted in those buildings and facilities. Facilities of the U.S. Postal Service are covered by the ABA. For more information or to file a complaint, contact:

U.S. Architectural and Transportation Barriers Compliance Board
1331 F Street, N.W., Suite 1000
Washington, D.C. 20004-1111

www.access-board.gov

(800) 872-2253 (voice)
(800) 993-2822 (TTY)

General Sources of Disability Rights Information

ADA Information Line
(800) 514-0301 (voice)
(800) 514-0383 (TTY)

www.ada.gov

Regional ADA and IT
Technical Assistance Centers
(800) 949-4232 (voice/TTY)

www.adata.org

Statute Citations

Air Carrier Access Act of 1986
49 U.S.C. § 41705

Implementing Regulation:
14 CFR Part 382

Americans with Disabilities Act of 1990
42 U.S.C. §§ 12101 et seq.

Implementing Regulations:
29 CFR Parts 1630, 1602 (Title I, EEOC)
28 CFR Part 35 (Title II, Department of Justice)
49 CFR Parts 27, 37, 38 (Title II, III, Department of Transportation)
28 CFR Part 36 (Title III, Department of Justice)
47 CFR §§ 64.601 et seq. (Title IV, FCC)

Architectural Barriers Act of 1968
42 U.S.C. §§ 4151 et seq.

Implementing Regulation:
41 CFR Subpart 101-19.6

Civil Rights of Institutionalized Persons Act
42 U.S.C. §§ 1997 et seq.

Fair Housing Amendments Act of 1988
42 U.S.C. §§ 3601 et seq.

Implementing Regulation:
24 CFR Parts 100 et seq.

Individuals with Disabilities Education Act
20 U.S.C. §§ 1400 et seq.

Implementing Regulation:
34 CFR Part 300

National Voter Registration Act of 1993
42 U.S.C. §§ 1973gg et seq.

Section 501 of the Rehabilitation Act of 1973, as amended
29 U.S.C. § 791

Implementing Regulation:
29 CFR § 1614.203

Section 503 of the Rehabilitation Act of 1973, as amended
29 U.S.C. § 793

Implementing Regulation:
41 CFR Part 60-741

Section 504 of the Rehabilitation Act of 1973, as amended
29 U.S.C. § 794

Over 20 Implementing Regulations for federally assisted programs, including:
34 CFR Part 104 (Department of Education)
45 CFR Part 84 (Department of Health and Human Services)
28 CFR §§ 42.501 et seq.

Over 95 Implementing Regulations for federally conducted programs, including:
28 CFR Part 39 (Department of Justice)

Section 508 of the Rehabilitation Act of 1973, as amended
29 U.S.C. § 794d

Telecommunications Act of 1996
47 U.S.C. §§ 255, 251(a)(2)

Voting Accessibility for the Elderly and Handicapped Act of 1984
42 U.S.C. §§ 1973ee et seq.

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HIV/AIDS TESTING, CONFIDENTIALITY & DISCRIMINATION

WHAT YOU NEED TO KNOW ABOUT NEW YORK LAW

LEGAL ACTION CENTER

225 VARICK STREET
NEW YORK, NY 10014

TEL (212) 243-1313
FAX (212) 675-0286

LACINFO@LAC.ORG

WWW.LAC.ORG

HIV/AIDS TESTING, CONFIDENTIALITY & DISCRIMINATION

WHAT YOU NEED TO KNOW ABOUT NEW YORK LAW

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The Legal Action Center wishes to thank the AIDS Institute of the New York State Department of Health, whose generous support made this manual possible, and has enabled the Center to provide legal assistance, training, and technical assistance to New Yorkers concerned with HIV/AIDS for more than two decades.

FOREWORD

The Legal Action Center has written this manual to help health and social service providers and individuals in New York State navigate some of the complex legal and practical issues raised by the HIV/AIDS epidemic: HIV testing, confidentiality, and discrimination.

The Legal Action Center is a leading expert in New York on these issues. The Center has authored many publications and provided training and advice to thousands of agencies and individuals throughout the state on the laws governing HIV testing and confidentiality and protecting people from HIV-based discrimination. The Center also provides legal representation to HIV-positive individuals on these issues. The Center is the only non-profit law and policy organization in the country whose mission is to fight discrimination against and protect the dignity of people with HIV/AIDS, alcohol/drug histories, and criminal records.

QUESTIONS ABOUT TOPICS IN THIS MANUAL?

CALL THE LEGAL ACTION CENTER, (212) 243-1313 or (800) 223-4044.

The Center offers FREE legal advice and help about HIV-related issues to HIV-positive individuals and their families as well as their service providers. Call (212) 243-1313 for information. Many of the Center's training materials are available at www.lac.org (click on "free publications" and/or "training/technical assistance").

Helpful resources are also available from —

NEW YORK STATE DEPARMTENT OF HEALTH, AIDS INSTITUTE
http://www.health.ny.gov/diseases/aids/

The AIDS Institute also has an HIV confidentiality hotline at (800) 962-5065.

TABLE OF CONTENTS

PART 1

HIV TESTING

INTRODUCTION

APPLICABLE LAWS AND REGULATIONS

Article 27-F of the New York State Public Health Law (N.Y. Pub. Health Law §§ 2780-2787) regulates virtually all HIV-related testing of individuals in New York state. It also establishes the basic rules regarding confidentiality of HIV-related information (see Part 2). Article 27-F, commonly called the HIV Testing and Confidentiality Law, went into effect in 1989 and has been amended several times. Section 2781 of this law establishes the basic rules regarding HIV testing. New York's 1998 HIV Reporting and Partner Notification Law (Public Health Law Article 21, Title III, §§ 2130-2139), whose rules went into effect in June 2000 and have since been amended, also contains provisions that affect HIV testing.

The State Department of Health is the "lead agency" responsible for setting statewide standards for and implementing these laws. Its regulations on HIV Testing, Reporting and Confidentiality of HIV-Related Information are contained in 10 New York Code of Rules and Regulations ("N.Y.C.R.R.") Part 63. The state agencies that monitor or fund most health and social service providers in New York have also issued regulations implementing the requirements of Article 27-F. Health and human service providers must become familiar with both the law and the regulations that apply to them. The Department of Health has a comprehensive website that provides additional materials about these laws at www.health.ny.gov/diseases/aids/regulations.

A separate law (Insurance Law § 2611) governs some aspects of HIV testing for insurance purposes. Its special rules are discussed below.

POLICY UNDERLYING ARTICLE 27-F

Testing rules

One of the major purposes of Article 27-F is to encourage individuals to come forward voluntarily for HIV testing, so that they can —

- make decisions about appropriate treatment, if infected with HIV; and
- change the behavior that puts themselves or others at risk of contracting or transmitting HIV infection.

The law reflects a legislative recognition that the most effective strategy to promote both the public health and individuals' health encourages individuals to make voluntary, informed decisions about HIV testing. The Legislature determined that the best way to accomplish this is to ensure that individuals have the option of being tested either anonymously or confidentially, get information prior to the test and post-test counseling, and receive assurances of confidentiality.

Confidentiality protections

When it enacted Article 27-F, the Legislature also said that strictly protecting the confidentiality of HIV testing and other HIV-related information about individuals is needed to limit the risk of discrimination and harm to an individual's privacy that may result from the inappropriate disclosure and misuse of that information. The law's confidentiality and disclosure rules are intended to do this.[1]

KEY DEFINITIONS

"HIV-related test or testing" means any laboratory test(s) or series of tests approved for the diagnosis of HIV. This includes HIV antibody tests (which indirectly reveal HIV by looking for its antibodies) and viral load tests (including a PCR, or polymerase chain reaction, test), which directly detect the HIV virus. This manual refers to all of these tests as "HIV tests."[2]

Note that the definition of "HIV-related test" does not include CD4 or T-cell tests, because they are used to check an individual's immune system; they do not detect the HIV virus itself. So Article 27-F's HIV test consent and counseling requirements do not apply to these tests. The law often does protect the confidentiality of this information, though (see page 25).

"Rapid HIV test or testing" means any laboratory screening test(s) approved for detecting antibodies or antigens to HIV that produces results in no more than sixty minutes and includes a confirmatory HIV related test if the screening test is reactive.[3]

"Capacity to consent" means an individual's ability, determined without regard to age —

- to understand and appreciate the nature and consequences of a proposed health care service, treatment or procedure (i.e., HIV test) or proposed disclosure of confidential HIV-related information, and
- to make an informed decision about whether to allow the proposed HIV test or disclosure.[4]

Pages 5-12 explain how this applies to HIV testing, and pages 39-41 explain how it applies to disclosures of HIV-related information.

[1] L. 1988, c. 584, § 1.
[2] N.Y. Pub. Health Law§ 2780(4).
[3] N.Y. Pub. Health Law § 2780(4-a).
[4] N.Y. Pub. Health Law § 2780(5).

Informed consent to HIV testing means a decision to allow HIV testing to be done, made after the person to be tested (or individual authorized pursuant to law to consent to health care for that person) has been given information the law requires be given to enable an informed decision to be made about whether to allow the HIV test to be performed.[5]

- **Oral informed consent** means consent provided orally for a rapid HIV test. Such consent shall be documented in the test subject's medical record by the person ordering the performance of the test.[6]

- **Written informed consent** means consent provided in a statement consenting to HIV related testing signed by the subject of the test who has capacity to consent or, when the subject lacks capacity to consent, by a person authorized pursuant to law to consent to health care for the subject after the subject or such other person has received the information described in the law.[7]

"Authorized pursuant to law to consent to health care" for another individual refers to a person who has specific legal authority to make health care decisions for the other person. The practical meaning and application of this term is explained in the sections of this manual that discuss "capacity to consent" for purposes of testing and disclosures (see pages 5-12 and 39-41).

[5] N.Y. Pub. Health Law § 2781(1),(2),(2-a-2-c),(3).
[6] N.Y. Pub. Health Law § 2781(1).
[7] N.Y. Pub. Health Law. § 2781(3).

I. GENERAL RULE: NO HIV TESTING WITHOUT INFORMED CONSENT

A. BASIC RULE

Article 27-F establishes the basic rule that no individual may be given an HIV test unless that individual first:

- is told about and given the opportunity to choose either *anonymous or confidential* HIV testing;
- receives pre-test information the law requires be given to enable the person tested to make an informed decision about whether to be tested; and
- then gives voluntary, informed consent to be tested, either orally (for rapid testing only) or in a signed, written consent (in all cases except in rapid HIV testing).[8]

If the person to be tested lacks "capacity to consent" to the HIV test (see discussion at pages 5-12), then the requirements for testing must be directed to the person authorized by law to consent to health care for the patient instead of the patient. The following sections explain each of these concepts and requirements.

B. ANONYMOUS OR CONFIDENTIAL TESTING

1. ANONYMOUS TESTING

Anonymous testing means that no information linking the individual's identity to the test request or results will be gathered or kept.[9] Records and blood specimens are identified by codes, not names. The results of anonymous HIV tests are not reported to the State Department of Health (see page 53).

Only public health agencies may offer anonymous counseling and testing. The main anonymous counseling and testing sites in New York are:

- New York City Department of Health Anonymous HIV Counseling and Testing Sites (call 311 or 212-639-9675 for the site locations) and
- New York State Department of Health Anonymous HIV Counseling and Testing Sites (call 1-800-541-AIDS for the sites in your area).

2. CONFIDENTIAL TESTING

Confidential testing means that the health care provider that orders or performs an HIV test will collect identifying information about the person tested and will record it and HIV-related counseling and testing information (including the test request and results) in the individual's medical record. The testing is "confidential" because the information is protected by law from unauthorized disclosure. If a confidential HIV test is positive, the state's HIV/AIDS case reporting law requires that the person's name and diagnosis be reported to the State Department of Health (see page 51).[10]

[8] N.Y. Pub. Health Law § 2781.
[9] N.Y. Pub. Health Law § 2781(4).
[10] N.Y. Pub. Health Law § 2130.

Most health care providers (except those listed above) can only offer confidential testing on site. However, all providers — except in the insurance context noted below — must either directly or through a representative inform every person considering testing that anonymous testing is available, and must refer those who wish to be tested anonymously to such a site.[11]

3. INSURANCE: NO ANONYMOUS OPTION

Insurers may legally ask people applying for health or life insurance to undergo an HIV-related test as a condition of applying for coverage. Although applicants are theoretically free to refuse testing, their application for insurance will probably be denied unless they consent.

People who are tested in connection with insurance applications are not required to receive the option of anonymous testing.[12] Less stringent counseling and informed consent requirements than those in Article 27-F apply.[13]

If applicants for insurance are tested, their identifying information and their HIV test results will go to the insurance company — and to a centralized computer, the Medical Information Bureau (MIB), to which most other insurance companies have access. Although the law requires insurers reporting to the MIB to use general codes to indicate "abnormal blood test" results (rather than reporting the specific HIV test result), those codes are generally understood and can be further investigated by other potential insurers.[14]

One way to deal with this dilemma is for persons who want to apply for insurance to undergo an anonymous HIV test before they begin the insurance application process. Then, knowing their test results, they can decide whether or not to go ahead with the application.

C. CAPACITY TO CONSENT TO AN HIV TEST

Article 27-F establishes the basic rule that any person with the "capacity to consent" has the right to decide whether to take an HIV test.

1. WHAT IS "CAPACITY TO CONSENT"?

Age, by itself, does not determine whether a person has "capacity to consent" to an HIV test (defined at page 2)[15]. An individualized assessment of capacity should be made in each case, by asking these two questions:

- Is this person able to understand and appreciate the nature and consequences of undergoing an HIV test?
- Is this person able to make an informed decision about whether to be tested?

If the answer to both of these questions is yes, then the individual has capacity to consent and the right to decide whether to be tested.

[11] N.Y. Pub. Health Law § 2781(4).
[12] *Id.*
[13] *See* N.Y. Ins. Law § 2611 and pages 22-23.
[14] N.Y. Ins. Law § 321(d).
[15] N.Y. Pub. Health Law § 2780(5).

2. WHAT TO DO IF SOMEONE LACKS CAPACITY TO CONSENT?

If the person lacks capacity to consent to an HIV test based on the two-part test, above, then those with responsibility for assessing the individual's capacity should either:

- determine whether another person is legally authorized to consent to health care for the individual. Possibilities include the parent/guardian of a minor (see pages 6-10), "agent" designated through a health care proxy (see page 11), "surrogate" selected to make decisions under the Family Health Care and Decisions Act (see pages 11-12); or court appointed guardian (see page 10); *or*
- defer or decide against testing of the individual in question.

Whenever a question arises about a particular individual's capacity to consent to an HIV test, the provider should document in the medical record that an assessment of capacity was done and, if the individual is deemed to lack capacity, the reasons for that conclusion.

3. WHO ASSESSES CAPACITY TO CONSENT?

Article 27-F does not specify who determines whether a person has the capacity to consent to an HIV test. All health and human service agencies that offer on-site HIV testing should designate the staff with responsibility for making such assessments.

Note, however, that if the provider believes that the patient does not have capacity to consent to an HIV test and wants to invoke the provisions of the health care proxy law or Family Health Care Decisions Act so that someone else can authorize the test (see pages 11-12), additional procedures are required, including the involvement of an attending physician (see pages 11-12).

4. APPLICATION TO SPECIFIC GROUPS: MINORS, PEOPLE ADJUDICATED INCOMPETENT, AND OTHER INDIVIDUALS WITH IMPAIRMENTS

a. NEWBORNS, INFANTS AND VERY YOUNG CHILDREN

i. DO THEY HAVE CAPACITY?

Infants and very young children will not have the capacity to consent to an HIV test because they lack the ability to understand or make an informed decision about the test. Except for newborn testing (which is done whether or not the mother consents, as explained at page 20), the following rules apply to infants and young children.

ii. WHO MAY CONSENT ON THEIR BEHALF?

The "person authorized pursuant to law to consent to health care for such [child]" has the sole right to consent to testing of the infant or young child.[16]

In intact families, the birth parent(s) of the child generally have the legal authority to consent to health care for the child. This is so even if the parent is

[16] N.Y. Pub. Health Law § 2781(1)

also a minor.[17] Thus the consent must be signed by a parent or in very limited cases another person designated by the parent.[18]

In cases where both parents have legal authority to consent to health care for their child, either may consent.[19] If the two parents disagree, the provider has a dilemma. Consent authorizes but does not compel any provider to perform an HIV test. So, in these cases, a provider may want to look into the facts before deciding to test, and may decide to do so only if it serves a legitimate clinical purpose. Also, if a provider is not sure whether a parent has legal authority to consent to his or her child's health care, the provider may wish to verify this before proceeding with the test. This question is only likely to arise if the parents are separated or divorced; if only one parent has been given legal custody and health care decision-making authority for the child, that parent's consent will be needed.

When the infant or child is in foster care, the foster care agency must conduct an HIV risk assessment.[20] If this assessment identifies an HIV risk for the child, consent for the HIV test can be obtained in different ways depending on how the child was placed in foster care:

- voluntary placement. When a child has been placed in foster care voluntarily by his or her birth parent(s) or guardian, or placed as a Person In Need of Supervision (PINS) or Juvenile Delinquent, the parent's or guardian's consent to the test is required unless a court orders otherwise. If the parent or guardian does not consent or cannot be located, the child may not be tested unless a court order authorizes the test.[21]

  According to guidelines issued by the state agency responsible for overseeing foster care (formerly the Department of Social Services, now the Office of Children and Family Services (OCFS)), courts may order HIV testing of a foster child upon a finding of "urgent medical necessity," which OCFS says may exist when –

  - » a child entering care has previously tested positive and/or has symptoms related to HIV infection requiring immediate medical attention,
  - » an infant or pre-school child has been abandoned, or
  - » the child's parent has HIV/AIDS or has died from HIV/AIDS.[22]

- involuntary placement. When a child has been placed in foster care as a result of child abuse or neglect proceedings, anyone wishing to test the child must seek the birth parent's or guardian's consent. If the parent/guardian refuses or is unable to consent within 10 days

[17] *See* N.Y. Pub. Health Law § 2504(2): anyone who has borne a child may give consent for "medical, dental, health and hospital services for his or her child."

[18] N.Y. Pub. Health Law § 2504.

[19] *Id.*

[20] 18 N.Y.C.R.R. § 441.22.

[21] *Id.*

[22] *Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure*, 97 ADM-15, issued July 24, 1997; see pp. 16, 24-26.

of the request, the local social services commissioner may consent.[23] (See pages 40-41 for a discussion of who can authorize the disclosure of HIV test results of a minor who lacks capacity to consent.)[24]

When a child has been adopted, the adoptive parents generally assume all parental rights; thus they (not the birth parents) have the legal authority to consent to health care for, and to decide about HIV testing of, the adopted infant or young child. Before an adoption is finalized, the rules governing children in foster care generally apply. (See page 40 regarding disclosure of HIV-related information about adopted children.)

Note: These guidelines govern consent for testing only while a birth, foster or adoptive child is so young as to lack capacity to consent. Once a minor has the capacity to consent (as discussed next), s/he alone has the right to decide whether or not to be tested.

b. OLDER MINORS (UNDER THE AGE OF 18)

i. DO THEY HAVE CAPACITY?

A legal minor (under age 18) may have the capacity to consent and, thus, the right to decide whether to be tested. Since age itself does not determine capacity, an individualized assessment must be done of every older child's or adolescent's actual ability to understand the nature and consequences of being tested for HIV and to make an informed decision.

ii. WHO MAY CONSENT FOR THOSE WHO LACK CAPACITY?

Only if an individualized evaluation leads to the conclusion that a particular minor lacks capacity to consent to an HIV test may a provider consider whether to seek consent instead from a person legally authorized to consent to health care for the minor. Ordinarily, this will be the minor's parent(s) or legal guardian. In the following special cases, however, parents and guardians do not have the legal authority to consent to HIV testing of their minor children.

iii. SPECIAL CASES WHERE ONLY THE MINOR CAN DECIDE

In New York, certain minors have the right to make some health care decisions for themselves (or for their own children). Parental consent is neither required, nor legally effective, to authorize testing of these minors.

Married minors and minor parents: testing themselves. Any person (even if under the age of 18) who has married or is the parent of a child may give effective consent for "medical, dental, health and hospital services for him/herself, and the consent of no other person shall be necessary."[25]

[23] 18 N.Y.C.R.R. § 441.22.

[24] These rules are discussed in detail in a manual issued by the New York State Office of Children and Family Services, entitled Working Together: Health Services for Children in Foster Care, issued March 9, 2009, available at: http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp.

[25] N.Y. Pub. Health Law § 2504(1).

Thus a minor who is married or a parent (even if not married) is probably the only person who has the right to decide whether to consent to an HIV test. If a married minor or minor parent decides not to be tested, consent by his or her parent(s) or guardian cannot override that decision. If such a minor lacks capacity to consent, that person is treated as an adult without capacity to consent as discussed below.

Pregnant minors. Any person who is pregnant may give effective consent for "medical, dental, health and hospital services relating to prenatal care."[26] Consequently, if HIV testing is offered or considered in the context of prenatal care, a pregnant minor has the right to decide whether or not to be tested. If that minor refuses to consent, no test may be done. Her parents may not be contacted or asked to consent to have her tested (see page 49). If the minor lacks capacity to consent, she should be treated as an person without capacity to consent, as described below.

Minor parents: testing their child. Any person (even if under the age of 18) who has been married or has borne a child may give effective consent for "medical, dental, health and hospital services for his or her child."[27]

Since the minor in these special cases is the only person "authorized pursuant to law to consent to health care" for the child, the minor alone has the right to decide whether his or her child should undergo an HIV test. The minor's parent or legal guardian cannot be asked to consent instead.

iv. MINORS: CONSENT TO HIV TREATMENT VERSUS HIV TESTS

While Article 27-F gives minors who have capacity to consent the right to decide whether to be tested for HIV, it does not govern who may authorize a minor's treatment for HIV/AIDS.

Under New York law, a parent's (or guardian's) consent is generally required before a minor may be given medical, dental, health or hospital services. The law, however, does allow a minor to receive medical treatment without parental consent if the minor is married, pregnant, or has borne a child, or if in a physician's judgment an emergency exists that requires immediate medical attention, and an attempt to get parental consent would delay treatment, increasing the risk to the minor's life or health.[28] Some people have interpreted this "emergency" exception as authorizing providers to treat minors for HIV without the consent of a parent or guardian.

Other provisions of New York law give minors the legal authority to consent to treatment for particular health problems, including sexually transmitted diseases[29]

[26] N.Y. Pub. Health Law § 2504(3).
[27] N.Y. Pub. Health Law § 2504(2).
[28] N.Y. Pub. Health Law § 2504.
[29] N.Y. Pub. Health Law § 2305(2).

and, within limits, mental health problems[30] or drug or alcohol problems.[31] These laws recognize that, given the highly personal and stigmatizing nature of these health problems, minors might not seek needed treatment if parental consent were required. But no comparable law explicitly allows minors to be treated for HIV/AIDS without parental involvement or consent.

So, while Article 27-F gives minors who have capacity to consent the right to decide about HIV testing on their own, it does not address whether parental consent is needed to authorize a minor's treatment for HIV/AIDS. Health care providers must look to the general rules of Public Health Law § 2504, just noted, to figure this out in each minor's case. (The rules governing when doctors may tell parents their minor child's HIV status, for instance to obtain needed parental consent to treat the minor for HIV, are described on pages 49-51.)

c. INDIVIDUALS WHO HAVE BEEN ADJUDICATED INCOMPETENT

i. DO THEY HAVE CAPACITY?

A person whom a court has declared to be incompetent to make health care or other decisions about him/herself will probably not have "capacity to consent" for purposes of HIV testing. The fact that a person may have psychiatric problems, physical illnesses or disabilities does not, by itself, mean that he lacks capacity to consent. Only if there has been a judicial adjudication of incompetency may a provider forego the individualized assessment of capacity required by Article 27-F, and seek consent from the person authorized to act for the individual.

ii. WHO MAY CONSENT ON THEIR BEHALF?

If the court has appointed someone to serve as such a person's legal guardian and has authorized that legal guardian to make health care decisions for the individual, then the legal guardian has the right to consent to HIV testing of that person. Alternatively, if the individual has signed a health care proxy, the health care "agent" named in the proxy may be authorized to consent to HIV testing of that person. (See "Health care proxies," below.)

d. OTHER INDIVIDUALS WITH TEMPORARY IMPAIRMENTS

i. DO THEY HAVE CAPACITY?

In some instances, questions about an individual's capacity to consent to an HIV test may arise either because of conditions that temporarily impair the person's cognitive abilities or judgment, or because of other physical or mental conditions. For example, a client might be intoxicated or under the influence of drugs, experiencing stress or other psychiatric problems, unconscious or comatose.

ii. WHO MAY CONSENT ON THEIR BEHALF?

If the individual has a temporary impairment (e.g., intoxication), it may be prudent to defer testing until the person has regained capacity to consent. In

[30] N.Y. Mental Hyg. Law § 33.21.
[31] N.Y. Mental Hyg. Law § 22.11.

other circumstances, however, if such a person has *not* been judicially declared incompetent, then the person with authority to consent to an HIV test might be:

- parents or guardians of minor children, as discussed above and on pages 39-41,
- a health care agent named in a health care proxy (see next section),or
- the "surrogate" decision maker as authorized by the Family Health Care Decisions Act (see section 6, below).

5. HEALTH CARE PROXIES

Under New York's "health care proxy" law (Public Health Law Article 29-C, §§ 2980-2994), a competent adult may designate another person as his/her "health care agent" for purposes of making health care decisions on his/her behalf in the event of the loss of ability to do so, as defined by statute.[32] An adult includes a person 18 years of age or older (or, as discussed above, a minor who is the parent of a child or is married).[33] Adults are presumed "competent" to appoint a health care agent unless adjudged incompetent "or otherwise adjudged not competent to appoint a health care agent" or if the court appointed a guardian.[34]

The person making a "health care proxy" may authorize the health care agent to make decisions about particular medical procedures and treatments (such as HIV testing specifically), or may give the agent general authority to make any and all health care decisions, which would allow the agent to consent to HIV testing or treatment even if the proxy did not mention HIV.

As was explained previously, Article 27-F provides that when a patient lacks capacity to consent to an HIV test, consent may be obtained from "a person authorized pursuant to law to consent to health care for [that] individual."[35] A health care proxy is simply an effective way of authorizing another person to provide that consent. If the patient who has signed the health care proxy regains the ability to make those medical decisions, though, the authority to decide whether to be tested shifts back to the patient. The attending physician makes the determination of whether the patient has the capacity to make the decision, though in specific circumstances the physician may be required to consult with a specialist.[36] The determination must be documented and notice of it must be provided in accordance with the statute.[37]

6. FAMILY HEALTH CARE DECISIONS ACT

Under the Family Health Care Decisions Act (the "FHCDA"), if a person becomes mentally incapacitated, health care decisions while the person is in a hospital or residential care facility can be made by an individual called a "surrogate."[38] It is not necessary to invoke the FHCDA if the patient has a guardian or a health care proxy.[39] While the FHCDA currently only applies in a hospital or residential care facility, the Legislature directed a task force to consider applying

[32] N.Y. Pub. Health Law § 2980(3).
[33] N.Y. Pub. Health Law § 2980(1).
[34] N.Y. Pub. Health Law § 2981(1)(b).
[35] N.Y. Pub. Health Law § 2781(1).
[36] N.Y. Pub. Health Law § 2983.
[37] N.Y. Pub. Health Law §§ 2983(1) and (3).
[38] N.Y. Pub. Health Law §§ 2994-a, 2994-d.
[39] N.Y. Pub. Health Law §§ 2994-b(2) and (3)(a).

it in other settings.[40] The attending physician makes an initial determination that the patient lacks decision-making capacity, though in specific circumstances, may be required to consult with another medical professional. The determination must be documented and notice of it must be provided in accordance with the statute.[41]

If a patient is incapacitated, a surrogate or the health care facility can make medical decisions for the patient, including HIV testing, following the procedures laid out in the FHCDA. If, however, the patient objects to the determination of incapacitation, to the choice of surrogate, or to a health care decision made on the patient's behalf, the patient's decision must prevail unless there is a finding by a court or other legal basis to override the patient's decision.[42]

The surrogate should be assigned based on the order in the following list. If the person whose relationship is highest on the list is not reasonably available, willing or competent to act, that person can designate any other person on the list as the surrogate as long as someone with higher priority does not object. Otherwise, the next highest person on the list is surrogate.

- Guardian specifically authorized by the court to make such decisions
- Spouse (if not legally separated) or domestic partner
- Son or daughter 18 years of age or older
- Parent
- Sibling 18 years of age or older
- Close friend.[43]

Additionally, if a surrogate is not available for the patient, the patient can still receive HIV-related testing (considered a "major medical procedure" under the FHCDA) when physicians recommend the testing for the patient following the procedures set out in the FHCDA.[44]

Decisions made for the patient under FHCDA must be made in accordance with the patient's wishes, including religious or moral beliefs. If the patient's wishes are not known and cannot be reasonably determined, decisions should be based on the patient's best interests, considering the factors laid out in the statute.[45]

D. PRE-TEST INFORMATION REQUIREMENTS

1. GENERAL RULE

Before anyone decides whether to consent to any HIV-related test, that person must receive the information about HIV required by the Public Health Law. This information can be given directly

[40] New York State Bar Association Frequently Asked Questions about the Family Health Care Decisions Act, revised January 9, 2011, available at www.nysba.org/Content/NavigationMenu/PublicResources/ FamilyHealthCareDecisionsActInformationCenter/FAQ_HTML.htm.

[41] N.Y. Pub. Health Law § 2994-c.

[42] N.Y. Pub. Health Law §2994-c(6).

[43] N.Y. Pub. Health Law § 2994-d.

[44] N.Y. Pub. Health Law § 2994-g(4); Department of Health, *Fact Sheet: Family Health Care Decisions Act & HIV/ AIDS*, available at http://www.health.ny.gov/diseases/aids/regulations/fhcda/ai_fact_sheet.htm ("DOH Fact Sheet: FHCDA").

[45] N.Y. Pub. Health Law § 2994-d(4); DOH Fact Sheet: FHCDA http://www.health.ny.gov/diseases/aids/regulations/fhcda/ai_fact_sheet.htm.

or through a representative, and it can be in oral, written or electronic form.[46] For example, the requirement can be satisfied by use of an HIV test consent form that contains the required pre-test information (see page 14 regarding model forms available from the Department of Health), or by use of a video loop shown in a waiting area. If the individual lacks capacity to consent, the information must be given to the person authorized by law to consent on his/her behalf. (The exceptions to the general rule requiring this information, and the special rules that apply to applicants for insurance, are discussed at pages 20-23.)

2. CONTENT OF REQUIRED INFORMATION

Prior to testing, the following information must be provided:

- HIV causes AIDS and can be transmitted through sexual activities and needle-sharing, by pregnant women to their fetuses, and through breast feeding infants;
- there is treatment for HIV that can help an individual stay healthy;
- individuals with HIV or AIDS can adopt safe practices to protect un-infected and infected people in their lives from becoming infected or multiply infected with HIV;
- testing is voluntary and can be done anonymously at a public testing center;
- the law protects the confidentiality of HIV related test results;
- the law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences; and
- the law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

Providers must have protocols in place to ensure compliance with these requirements.[47]

E. CONSENT FOR AN HIV TEST

1. RAPID HIV TESTING

Oral consent is sufficient for rapid HIV testing (but written consent is required in correctional facilities) and must be documented in the individual's medical record by the person ordering the test.[48] DOH guidance suggests that in non-medical settings, consent should be noted in the program's "testing documentation."[49] "Rapid HIV test or testing" means any laboratory screening test(s) approved for detecting antibodies to HIV that produce results in sixty minutes or less, and that includes a confirmatory HIV related test if the screening test is reactive.[50]

[46] N.Y. Pub. Health Law § 2781(3); 10 N.Y.C.R.R. § 63.3 (b).
[47] N.Y. Pub. Health Law § 2781(3).
[48] N.Y. Pub. Health Law § 2781(1) and (2-c).
[49] DOH HIV Testing FAQs Dec. 2010, http://www.health.ny.gov/diseases/aids/testing/law/faqs.htm.
[50] N.Y. Pub. Health Law § 2780(4-a).

2. HIV TESTING GENERALLY

Written consent is required for all HIV tests except rapid tests. (As discussed above, however, written consent is required for rapid tests performed in correctional facilities). Written consent can be in the form of:

- a simple signed statement consenting to the test after the person has received the required pre-test information; or
- a signed general written consent for medical care or any health care service, *but only if* the form has a clearly marked place next to the signature where the individual (or the person legally authorized to consent) can specifically decline in writing the HIV related testing.[51]

The Department of Health has developed model forms (see Appendices A and B), but providers may create their own forms consistent with these models and do *not* need Department of Health approval for these forms. The forms must be written clearly using words with common meanings.[52]

Certification of consent does *not* need to be provided to the laboratory.

3. PEOPLE WITH LANGUAGE BARRIERS

HIV test consent forms contain crucial information that must be fully understood by those who are deciding whether to undergo HIV testing, or to consent to testing on another's behalf. If an individual's ability to read is questionable, the consent form should be read to that person. Forms written in a person's preferred language should be used. The Department of Health website provides consent forms in many languages.[53] The pre-test HIV information should also be provided in the person's preferred language.

4. DURATION OF CONSENT TO AN HIV TEST

Written or oral informed consent for HIV related testing can be for a single test, for a specified period of time until expiration, or open-ended. When an HIV related test is subsequently ordered based on ongoing consent, the person ordering it must orally notify the test subject (or, if the test subject lacks capacity to consent, then the individual authorized to consent to care for such individual) that an HIV test will be conducted at such time, and must document that notification in the patient's record.[54]

5. REVOKING CONSENT TO AN HIV TEST

Consent to an HIV test may be revoked or withdrawn at any time.[55] People may revoke their consent either orally or in writing; it is not permissible to require or honor only written revocations. However, if the original consent form is retained in the medical or other records the client's revocation must also be noted in the record, including the date of revocation and the name of the person making the note. The revocation should be either on the consent form itself or in another way that ensures no one will perform any HIV test in reliance on the revoked consent.[56]

[51] N.Y. Pub. Health Law §§ 2781(2) and (2-a).
[52] N.Y. Pub. Health Law § 2786(1).
[53] Consent forms in many languages are available at: http://www.health.ny.gov/diseases/aids/testing/index.htm.
[54] N.Y. Pub. Health Law § 2781(2-b).
[55] *Id.*
[56] DOH HIV Testing FAQs Dec. 2010, http://www.health.ny.gov/diseases/aids/testing/law/faqs.htm.

F. POST-TEST COUNSELING

1. GENERAL RULE

a. POSITIVE TEST RESULTS.

Post-test counseling (or referral for such counseling) must be provided whenever a test indicates evidence of HIV infection. The counseling must be provided to a person who has been tested, or if the individual tested lacks capacity to consent, then to the person who provided consent and, to the extent it is beneficial, to the person tested.[57] While Article 27-F does not mandate that post-test counseling always be done in person, good, sensitive practice generally requires it when the test is positive.

Post-test counseling for *confirmed positive results* must include information about:

- how to cope with the emotional consequences of learning the result;
- discrimination that could result from disclosure of the test result;
- the importance of precautions to prevent HIV transmission to others;
- the ability to release or revoke the release of confidential HIV-related information;
- HIV reporting requirements for epidemiologic monitoring of the HIV/AIDS epidemic;
- the importance of notifying contacts in order to prevent transmission and to allow early access to HIV testing, health care and prevention services, and a description of notification options and assistance available;
- though not required in post-test counseling, providers should advise people that their refusal to reveal contacts or otherwise cooperate with contact notification efforts is not illegal, and there are no penalties for not providing the names of contacts;[58]
- the possible risk of domestic violence resulting from notification of any partner will be assessed, through a domestic violence screening conducted during post-test counseling (pages 54-60 discuss the contact reporting and notification rules);
- the requirement that known contacts (including a known spouse) will be reported and that protected persons will also be requested to cooperate in contact notification efforts and may name additional contacts they wish to have notified with the assistance of the provider or authorized public health official;
- that the tested person's name or other identifying information is not disclosed to anyone during the contact notification process;
- the provider's responsibility for making an appointment for newly diagnosed persons to receive follow-up HIV medical care (discussed below);
- available medical services, including the location and telephone numbers of treatment sites, information on the use of HIV medications for

[57] N.Y. Pub. Health Law § 2781(5); 10 N.Y.C.R.R. 63.3(d).
[58] N.Y. Pub. Health Law § 2136.

prophylaxis and treatment and peer group support, access to prevention services and assistance, if needed, in obtaining these services; and

- prevention of perinatal transmission.[59]

b. NEGATIVE TEST RESULTS.

When a test does not indicate evidence of HIV infection, information concerning the risks of high-risk sexual or needle-sharing behavior must be provided to the subject of the test (or, if the subject lacks capacity to consent, to the person authorized to consent to health care for that person). The negative result and required information may be provided in-person, by mail, electronic messaging, or telephone, provided that patient confidentiality is reasonably protected. The information concerning behavior risks may be given by oral or written reference to materials previously provided.[60]

2. FOLLOW-UP CARE

The person who ordered the HIV test (or his/her representative) must provide or arrange with a health care provider for an appointment for follow-up HIV medical care for the person who tested positive, with that person's consent.[61] According to the Department of Health, that consent may be oral or written. Simply providing the patient with contact information for follow up care is not sufficient. The name of the provider or facility offering the follow up appointment must be documented in the patient's record. This requirement applies to any provider who provided the HIV test resulting in a diagnosis, even if the provider was not mandated to offer the test (with limited exceptions such as testing to obtain body parts for transplant or in a blinded research protocol).[62]

3. PERSONS WHO DO NOT WISH TO LEARN THEIR HIV TEST RESULTS

Individuals who have undergone HIV testing have a legal right to choose not to be told the results of the test. When individuals test positive but do not return for their test results, however, providers may contact the New York State Department of Health's HIV Partner Services (PS) program or New York City Department of Health Contact Notification Assistance Program (CNAP) (see page 57), who can assist the provider in locating the individual to advise them to return to the provider for the test results.

a. LIABILITY FOR TELLING OR NOT TELLING HIV TEST RESULTS

Health care providers who have performed or know the results of an HIV test often ask whether they have a legal obligation to tell their patient the specific test results if the patient does not want to know.

The answer is no: providers do not have a legal duty to disclose the results to the tested person — although ethical, therapeutic or professional concerns may make them wish to do so. Health and mental health professionals generally have a legal duty to take reasonable care of their patients. This includes an obligation to give patients sufficient information (known to the health care provider) to make informed decisions about

[59] 10 N.Y.C.R.R. § 63.3(e).
[60] *Id.*
[61] N.Y. Pub. Health Law § 2782(5-a); 10 N.Y.C.R.R. § 63.3(e).
[62] DOH HIV Testing FAQs Dec. 2010, http://www.health.ny.gov/diseases/aids/testing/law/faqs.htm.

their health care, and take proper care of themselves and protect others from their transmissible illness.

But it is possible to relay this kind of information to a patient without giving the specific test result or diagnosis, if the patient does not want to know the specific result. To force specific medical information upon an unwilling patient might subject health professionals to possible legal claims for malpractice or professional misconduct, intentional infliction of emotional distress, or related claims (though no such cases have come to the authors' attention).

A person's decision not to receive his test results, and information about any post-test counseling that was performed, should be documented in that person's medical record.

b. SOME PRACTICAL SUGGESTIONS

Article 27-F mandates post-test counseling only "at the time of communicating the test result to the subject of the test."[63] Thus, such counseling may not be legally mandated for persons who choose not to know their test results. However, it is advisable to offer them post-test counseling anyway For example, the patient could be counseled to act "as if" he were HIV-infected, and be educated about HIV transmission and risk reduction behaviors.

In addition, if the test was done on a confidential, as opposed to anonymous, basis, it is advisable to tell the individual that the test results will be recorded in his or her medical record.[64] Arrangements should also be made to ensure that others who may have access to the individual's medical records and/or the HIV test result know that the individual does not wish to know the test results.

Finally, even when tested persons remain ignorant of their own test results, their names and known contacts must be reported to public health authorities (see pages 51-60).

[63] N.Y. Pub. Health Law § 2781(5).
[64] N.Y. Pub. Health Law § 2782(8).

II. REQUIRED OFFER OF HIV TESTING

HIV testing must be offered to all persons between the ages of 13 and 64 receiving hospital or primary care services with limited exceptions noted in the law.[65] The specifics about who must offer an HIV test and who must be offered the test are described below.

A. WHO MUST OFFER HIV TESTING?

An HIV test must be offered in the following settings and by the following providers:

- emergency departments or providers of inpatient services in general hospitals;
- outpatient departments of such hospitals when they provide primary care services;
- "diagnostic and treatment center[s]" when they provides primary care services; and
- physicians, physician assistants, nurse practitioners or midwives who provide primary care services. This includes primary care service providers in settings such as nursing homes, school-based clinics, college health services, retail clinics, urgent care centers, employee health services, and family planning sites.[66]

Note: Primary care services include family medicine, general pediatrics, primary care, internal medicine, primary care obstetrics, or primary care gynecology, regardless of board certification.[67]

B. WHO MUST BE OFFERED HIV TESTING BY THE PROVIDERS LISTED ABOVE?

The following individuals must be offered an HIV test in the settings noted above.

- everyone between the ages of 13 and 64; and
- people younger or older if there is indication of risk activity.

The only exceptions are where the medical practitioner reasonably believes one of the following:

- the patient is being treated for a life threatening emergency;
- the patient has previously been offered or been the subject of an HIV-related test;
- and the need for a test is not otherwise indicated; or
- the patient lacks the capacity to consent to an HIV related test.[68]

The offer of testing must be made in "culturally and linguistically appropriate" ways.[69] After the initial offer, the test should be offered again annually to people whose behavior indicates increased risk

[65] N.Y. Pub. Health Law § 2781-a.
[66] *Id.* and DOH HIV Testing FAQs Dec. 2010, http://www.health.ny.gov/diseases/aids/testing/law/faqs.htm.
[67] N.Y. Pub. Health Law § 2781-a(2).
[68] N.Y. Pub. Health Law § 2781-a (1).
[69] N.Y. Pub. Health Law § 2781-a (3).

such as sexual or drug use activity, and more often for those with very high-risk behaviors such as unprotected anal intercourse. Providers should consider setting a low threshold for recommending the test as many patients may not fully disclose their risk activities.[70] Though not legally required, it may be prudent to document the offer of a test. The Department of Health's model form for documenting the offer of testing is attached as Appendix C.

[70] DOH HIV Testing FAQs, Dec. 2010 at http://www.health.ny.gov/diseases/aids/testing/law/faqs.htm.

III. HIV TESTING WITHOUT CONSENT AND OTHER SPECIAL RULES

A. EXCEPTIONS: HIV TESTING WITHOUT CONSENT

Article 27-F specifies the following situations in which HIV testing may be done without providing pre-test information or obtaining consent.[71]

1. NEWBORN TESTING

All newborns must be tested for HIV, whether or not the mother consents.[72] Although consent is not needed, a mother/parent must be informed about the purpose and need for newborn testing.[73] If there is no available HIV test result for the mother obtained during this pregnancy, expedited newborn testing must be done. An immediate screening test of the mother should be arranged with her consent, or a test of the newborn must be arranged as soon as possible but no longer than 12 hours after the mother consents or after the birth of the child.[74] Efforts to provide counseling to the mother and obtain her consent should be documented in the newborn's medical record.

Testing of pregnant women, on the other hand, is voluntary and may be done only with the woman's informed consent. The Department of Health does require all prenatal care providers to:

- counsel and encourage pregnant women to be tested as early as possible during the pregnancy; and
- inform pregnant women about the mandatory newborn testing requirements.

Additionally, the Department of Health urges prenatal providers in areas where HIV seroprevalence is high to recommend repeat HIV testing in the third trimester of pregnancy in case the mother became infected after early testing.[75]

2. OCCUPATIONAL EXPOSURE AND HIV TESTING

Under 2010 amendments to Article 27-F, individuals who believe that they may have been exposed to HIV in the course of performing their job (e.g., through a needle stick) may test the source of an occupational exposure to determine his or her HIV status if all of the following conditions exist:

- the person who is the source of the exposure is deceased, comatose, or determined to lack mental capacity to consent to an HIV related test and is not reasonably expected to recover in time for the exposed person to receive appropriate medical treatment; and

[71] N.Y. Pub. Health Law §§ 2781(1) and 2781(6).
[72] N.Y. Pub. Health Law §§ 2500-f; 2781(6)(d); 10 N.Y.C.R.R. § 69-1.2.
[73] 10 N.Y.C.R.R. § 69-1.5.
[74] 10 N.Y.C.R.R. § 69-1.3(l)(2).
[75] For more information, see the Department of Health's January 2004 Letter Regarding Regulatory Changes for Expedited HIV Testing in Labor and Delivery, available at www.health.ny.gov/diseases/aids/testing/perinatal/expedited/2004_prenatal_hiv_testing_letter.htm.

- the exposure created a significant risk of transmitting HIV as defined by 10 N.Y.C.R.R. § 63.10; and
- no one with the legal authority to consent to the HIV related test is available or likely to become available in time for the exposed person to receive appropriate treatment; and
- the exposed person will benefit medically by knowing the source's HIV test results, (which must be documented in that person's medical record).[76]

When these conditions are met, a provider may test the source person. If an HIV test is done, it must be done anonymously; only the test results – not the identity of the source – may be disclosed to the exposed person's health care professional, and only for the limited purpose of assisting that person with making decisions regarding treatment. The test results shall not be disclosed to the source person or put in that person's medical record.[77]

Note: if the Family Health Care Decisions Act applies and a surrogate is available, then this procedure would not apply.

If the possible "source" of the exposure has the capacity to consent to such a test and declines testing, that person cannot be required to undergo an HIV test. Not even a court has the authority to mandate such a test. If the source patient was previously tested for HIV, in some situations those results may be disclosed to the exposed person (see pages 62-64).

3. MEDICAL RESEARCH; TRANSPLANTATION

Health care providers and health facilities may perform HIV tests without consent when they get or use human body parts or fluids for medical research or therapy, or for transplantation. However, if they disclose the HIV test results to the person tested, they must provide that person with post-test counseling, as outlined above.[78]

4. RESEARCH (WITHOUT IDENTIFYING INFORMATION)

HIV testing may be done without counseling or consent for the purpose of research, but only if the testing is done in a manner that ensures the identity of the subject is not known and may not be retrieved by the researcher.[79]

5. DECEASED PERSONS

HIV tests may be performed on people who have died, when the test is done to determine the cause of death, or for epidemiological purposes. In these two circumstances, no counseling or consent is required for anyone (including surviving family members).[80]

6. INDIVIDUALS WITH SEX OFFENSE CONVICTIONS AND INDICTMENTS

When an adult or juvenile is convicted of or indicted for certain sex offenses, the victim may request the court to mandate the convicted/indicted person to undergo an HIV test.

[76] N.Y. Pub. Health Law § 2781(6)(e). For additional information, see DOH HIV Testing FAQs Dec. 2010, http://www.health.ny.gov/diseases/aids/testing/law/faqs.htm.

[77] *Id.*

[78] N.Y. Pub. Health Law § 2781(6)(a).

[79] N.Y. Pub. Health Law § 2781(6)(b).

[80] N.Y. Pub. Health Law § 2781(6)(c).

The court must issue the order upon such request.[81] (See page 74 for a discussion of who has access to the test results.)

7. COURT-ORDERED TESTING WHERE PARTY'S HIV STATUS IS "IN CONTROVERSY"

A court may order HIV testing without consent under § 3121 of the Civil Practice Law and Rules.[82] This provision allows a court to order a party in a civil court case to undergo medical tests or examinations if that party's "mental or physical condition" is "in controversy" in that case.

This rarely occurs because a party's HIV status is rarely "in controversy." But one type of case where this issue can arise is a tort case based on a sexual partner's non-disclosure of HIV status. This arises when person A sues person B for money damages, claiming that A contracted HIV from B because B knew, but did not divulge, his or her HIV infection prior to having sex. Because a court may decide that each party's HIV status is central to these claims, both the plaintiff and defendant in these cases could be ordered to undergo an HIV test.

CPLR § 3121's medical examination provisions can only be invoked after an action has been commenced.[83] It appears that § 3121 cannot be used by someone who wants to force another person to undergo an HIV test but has no independent legal claim to pursue.

8. TESTING "SPECIFICALLY AUTHORIZED OR REQUIRED BY A STATE OR FEDERAL LAW"

Article 27-F provides that non-consensual HIV testing may be "specifically authorized or required" by other state or federal laws. Article 27-F would not override such other state or federal laws.[84]

New York laws As of the publishing of this manual New York had no laws (other than the provisions described above) specifically authorizing or mandating HIV testing without consent. Some courts have nonetheless ordered defendants in certain criminal cases to undergo HIV testing. These have primarily involved defendants charged with sexual assault crimes, prostitution, or assaults on law enforcement officers alleging bites or contacts with the defendant's blood or body fluids. Article 27-F does not expressly allow such testing, and its legality is hotly debated.

Federal law Federal laws and regulations authorize mandatory HIV testing in certain circumstances, including:

- prisoners in federal correctional facilities; and
- the military

B. HIV TESTING IN CONNECTION WITH INSURANCE APPLICATIONS

Special, less stringent rules apply when an insurance company asks or requires an applicant for health or life insurance to undergo an HIV test as a condition of coverage.

[81] N.Y. Pub. Health Law § 2785-a; N.Y. Crim. Proc. Law §§ 210.16; 390.15; N.Y. Fam. Ct. Act § 347.1.
[82] N.Y. Pub. Health Law § 2781(1).
[83] N.Y. C.P.L.R. 3121(a) (McKinney 2011).
[84] N.Y. Pub. Health Law § 2781(1).

1. INFORMATION PRIOR TO TESTING

The pre-test information usually required by Article 27-F is not required for testing in connection with an application for insurance. Insurance companies need only provide such applicants with "general information about AIDS and the transmission of HIV infection."[85] And, as noted previously (page 5), insurers do not have to offer anonymous testing.

2. CONSENT FORM

Although insurance applicants must give written informed consent to an HIV test, the written authorization (which must be dated and signed) need only contain the following information:

- a general description of the HIV test;
- a statement about the purpose of the test;
- a statement that a positive test result indicates the individual tested may develop AIDS and may wish to consider further independent testing;
- a statement that the individual tested may identify and designate on the consent form a person to whom the test result may be disclosed if the insurer makes an "adverse underwriting decision" (a decision to deny insurance or only offer insurance at a higher rate than usual); and
- the Department of Health's HIV Counseling Hotline number (1-800-872-2777), which provides information about the meaning of the test, referrals for counseling, and other information.[86]

3. POST-TEST COUNSELING

Post-test counseling is not required for HIV tests in connection with insurance applications. Insurers must let applicants (or their designee, e.g., a doctor) receive the test result.[87] The insurer also must notify the applicant of any "adverse underwriting decision" based on the result and let the applicant elect in writing to learn the test result directly or to designate someone else to learn the result.[88]

If the applicant wants to learn the test result directly, the insurer must give the applicant the Department of Health's HIV Counseling Hotline number (1-800-872-2777) and advise him/her to consult with a doctor about the test's meaning and need for counseling.[89]

C. HOME TESTING KITS

Article 27-F's requirements for informed consent do not prohibit a person from directly ordering an HIV test on a specimen and directly receiving the results of that test.[90]

[85] N.Y. Ins. Law § 2611(a).
[86] N.Y. Ins. Law § 2611(b).
[87] N.Y. Ins. Law § 2611(b)(4).
[88] N.Y. Pub. Health Law § 2611(c).
[89] N.Y. Ins. Law § 2611(c).
[90] 10 N.Y.C.R.R. § 63.3(h).

PART 2

CONFIDENTIALITY AND DISCLOSURE OF HIV-RELATED INFORMATION

INTRODUCTION

Section I of this Part explains the basic rule that prohibits many (but not all) people and agencies in New York State from disclosing HIV-related information about their patients, clients, and others. Section II explains the basic rule requiring that patients or clients provide consent before any disclosure of HIV-related information is made, and Section III explains the major exceptions that allow the disclosure of HIV-related information even without consent. In addition, the law requires most disclosures to be documented and accompanied by a notice prohibiting unauthorized re-disclosures. Section IV explains how to keep records about HIV-related information, and Section V explains the penalties for violating the confidentiality law.

I. GENERAL HIV CONFIDENTIALITY RULE: NO DISCLOSURE WITHOUT CONSENT UNLESS EXCEPTION APPLIES

A. THE BASIC RULE

General Rule Against Disclosing HIV-Related Information:

Covered persons may not disclose confidential HIV-related information about a protected individual unless:

- the individual consents to the disclosure in a proper, HIV-specific release form,or
- one of the law's specific exceptions permits the disclosure without consent

B. APPLICABLE LAWS AND REGULATIONS

1. NEW YORK'S LAW: ARTICLE 27-F

Article 27-F of the New York State Public Health Law [91] — the HIV Testing and Confidentiality Law — establishes the basic rules concerning confidentiality and disclosures of HIV-related information in this state. Section 2782 is the primary section concerning confidentiality and disclosures; § 2785 concerns court-ordered disclosures by health and social service providers. In addition to Article 27-F, the state's HIV Reporting and Partner Notification Law[92] governs confidentiality and disclosure of HIV-related information in the context of HIV/AIDS case reporting and contact (partner) notification activities. The policy rationale for Article 27-F's confidentiality protections is discussed in Part 1, pages 1-2. The Legislature subsequently enacted the HIV Reporting and Partner Notification Law to

- track the HIV epidemic and monitor the course of HIV disease in individuals, so as to improve its ability to plan and carry out needed prevention and treatment efforts; and
- curb the spread of HIV by promoting early activities to identify and alert the sexual and needle-sharing partners of infected individuals of their exposure and possible infection, so that they can protect themselves and others from acquiring or transmitting the virus.

The State Department of Health's "lead agency" regulations implementing these laws are in 10 N.Y.C.R.R. Part 63. Other state agencies also have issued regulations implementing Article 27-F's confidentiality and disclosure rules, and health and social service providers must comply with the specific Article 27-F regulations issued by the state agency that funds, licenses or regulates them. A note about wording: Since the law defines the sex and needle-sharing partners of infected individuals as "contacts," this manual also uses that term for the sake of clarity.

2. OTHER CONFIDENTIALITY LAWS AND RULES

a. OTHER POTENTIALLY APPLICABLE LAWS AND RULES

Other federal or state confidentiality requirements may also protect the confidentiality of HIV-related information. For example —

- most health care providers (as well as health plans and health care clearinghouses covered by this law) must also comply with the federal Health Insurance Portability and Accountability Act ("HIPAA").[93] HIPAA establishes minimum privacy protections for medical records and other "protected health information" ("PHI"). The interaction between Article 27-F and HIPAA is explained below in Section I.B.2.b.
- medical care providers must also comply with state laws and regulations protecting the confidentiality of medical records;
- many mental health care providers must comply with the confidentiality requirements of New York Mental Hygiene Law § 33(13);

[91] N.Y. Pub. Health Law §§ 2780-2787.

[92] N.Y. Pub. Health Law §§ 2130-2139.

[93] 42 U.S.C. § 1320d *et seq.* The U.S. Department of Health and Human Services ("HHS") regulations implementing HIPAA's privacy standards (the HIPAA "Privacy Rule") can be found at 45 C.F.R. Parts 160 and 164.

- drug and alcohol treatment programs must also comply with the federal law and regulations protecting the confidentiality of drug and alcohol patient records (42 U.S.C. §§ 290dd-2; 42 C.F.R. Part 2); and
- licensed health care and social service professionals must also comply with confidentiality requirements imposed by their state licensing agencies.

b. DEALING WITH MULTIPLE OR POTENTIALLY CONFLICTING CONFIDENTIALITY REQUIREMENTS

A good rule of thumb for health or social service providers subject both to Article 27-F and other confidentiality laws or regulations is: comply with all confidentiality requirements when possible; but when in doubt, abide by the stricter confidentiality rule. In general, Article 27-F will "trump" any less restrictive federal, state or local confidentiality law or regulation; but if other laws have more restrictive requirements, the stricter requirements apply.

HIPAA generally preempts, or overrides, any "contrary" state law provision.[94] "**Contrary**" means that a covered entity would "find it impossible to comply" with both the state and federal requirements, or that the state law "stands as an obstacle" to achieving HIPAA's purposes and objectives.[95] However, HIPAA does *not* preempt state laws that are "**more stringent**," which generally means that they provide greater privacy protection and/or give the individual more rights.[96] Because Article 27-F usually is more protective of privacy than HIPAA, health care providers will need to comply with Article 27-F's "more stringent" requirements.

C. POLICIES AND PROCEDURES AND IN-HOUSE TRAINING

The Department of Health's Article 27-F regulations require health care providers and health facilities to develop and implement policies and procedures to maintain the confidentiality of HIV-related information. These policies and procedures, which must be reviewed at least annually, must include

- provisions for employee in service education and updates when there are changes to relevant laws and regulations;
- protocols to prohibit employees, agents and contractors from discriminating (see Part 3);
- a list of the job titles and functions of employees with access to HIV-related information and a requirement that no one have such access unless they have first received HIV confidentiality education (see "internal communications" discussion on pages 44-45); and
- protocols for ensuring the security of records and procedures to handle requests by other parties for confidential HIV-related information (see "record-keeping issues" discussion at pages 76-81).[97] Other agency regulations have similar provisions.

[94] 45 C.F.R. § 160.203.
[95] 45 C.F.R. § 160.202.
[96] 45 C.F.R. §§ 164.202 and 164.203.
[97] 10 N.Y.C.R.R. § 63.9.

HIPAA's privacy and security provisions also require covered entities to take measures to ensure compliance with the law (see http://www.hhs.gov/ocr/privacy/). These include workforce training, appointment of a privacy officer, grievance processes, among other requirements.[98]

D. WHO IS PROTECTED

1. WHO IS PROTECTED BY ARTICLE 27-F

Article 27-F protects the confidentiality of HIV-related information about "protected individuals" and their "contacts."

A "**protected individual**" means a person who is the subject of an HIV-related test, or who has been diagnosed as having HIV infection, HIV-related illness, or AIDS.[99]

A "**contact**" means

- an identified spouse or sexual partner of a protected individual,
- a person identified as having shared needles or syringes with a protected individual, or
- a person who may have been occupationally exposed to HIV by a protected individual under circumstances that present a known risk of transmission.[100]

Deceased persons. Article 27-F does not say whether HIV-related information about an individual remains confidential after death. While some courts have suggested it does not, the State Department of Health has taken the position that it remains confidential after death. The law is clear, however, that HIV-related information about decedents may be released in the following circumstances:

- HIV case reporting and partner notification: HIV testing is permitted to determine cause of death. When HIV is diagnosed, the case must be reported to the Department of Health (see page 50); and public health authorities may notify the decedent's spouse or other known contacts of their possible exposure (see pages 54-60), but without revealing the decedent's identity.[101]

- Death certificates: The law permits HIV-related information to be listed in a death certificate and related documents identifying cause of death, and permits that information to be released to those who ordinarily would have access to the death certificate.[102] These include the spouse, children, parents, or lawful representative of the deceased individual, persons who can document a medical need or who need the document to establish a legal right or claim.[103] Death records are not subject to Freedom of Information Law requests.

[98] *See, e.g.*, 45 C.F.R. § 164.520 and 164.530.
[99] N.Y. Pub. Health Law § 2780(6).
[100] N.Y. Pub. Health Law § 2780(10).
[101] N.Y. Pub. Health Law § 2132.
[102] N.Y. Pub. Health Law § 2782(8).
[103] *See* N.Y. Pub. Health Law § 4174(1) for a full list.

- Occupational exposure: The HIV status — but not the identity — of a deceased person may be disclosed to an exposed worker if the incident meets the conditions required by the law's occupational exposure rule. (See pages 62-64.)
- Administrator/Executor: See page 75.

2. WHO IS PROTECTED BY HIPAA

Any individual who receives health care from a "covered entity" as defined by HIPAA (see page 35) is protected by HIPAA's privacy and security rules.

E. WHAT INFORMATION IS PROTECTED

1. WHAT INFORMATION IS PROTECTED BY ARTICLE 27-F

Article 27-F protects confidential HIV-related information. **"Confidential HIV-related information"** includes any information (written or oral), held by a person covered by Article 27-F, that does or reasonably could:

- reveal that an individual **had an HIV-related test**, and any test results;
  - » this includes information that a person has undergone one of the "HIV-related tests" that detect the virus itself — such as an HIV antibody test, RNA or DNA viral load tests, PCR (polymerase chain reaction) tests, and rapid HIV tests; it also includes information about tests that do not detect the virus but indicate HIV disease, such as a CD4 (T-cell) test (when used to diagnose or monitor HIV only), and bronchoscopy (which diagnoses PCP pneumonia, an AIDS-defining illness), even though those tests are not technically considered "HIV-related tests";
- reveal that an individual has been diagnosed as having **HIV infection or any related illness**, including **AIDS**; or
- identify the "**contacts**" of an individual who has been diagnosed as having HIV infection or any related illness (see page 27).[104]

a. EXAMPLES OF CONFIDENTIAL HIV-RELATED INFORMATION

Some examples of confidential HIV-related information are:

- a notation in a counseling agency client's chart that the client has had an HIV test or been offered a test (even if the results are not known or not recorded);
- a notation that a client's HIV test results were negative, positive or not definitive;
- a statement that a person has had PCP pneumonia, even without mention of HIV or AIDS (this information is protected because this illness

[104] N.Y. Pub. Health Law § 2780(7).

is associated with and triggers a diagnosis of AIDS, and information about this illness "could reasonably identify" that person as having HIV disease; the same is true for other CDC-defined "indicator" illnesses — ones that the federal Centers for Disease Control lists as illnesses indicative of AIDS in its definition of the disease);

- information that a person is taking a well-known HIV medication, such as a protease inhibitor;
- a report showing a low T-cell count or other lab test results confirming immune deficiency (unless the cause is shown not to be HIV-related);
- a notation in a client's chart that s/he is HIV positive, and a note in another part of the chart that he is living with his spouse, whose name and address are also noted. As his spouse and presumably his sexual partner, she is a "contact" of the HIV positive client (as defined in § 2780(10)).

b. EXAMPLES OF WHAT IS NOT CONFIDENTIAL HIV-RELATED INFORMATION

Examples of information that is not confidential HIV-related information are:

- a note in a patient's medical record that she was referred for HIV counseling and testing (however, if the record then notes that the patient was in fact tested for HIV or records her test result, that information is confidential);
- a note in a client's record that he is gay or bisexual or has a history of IV drug use. Without more, this information may suggest that the client has engaged in behavior known to create a risk of HIV infection, but it does not necessarily lead to that conclusion. However, if the client's record explicitly reflects that an HIV risk assessment was done — e.g., it notes that "client's history of having unsafe sex with other men suggests he may have HIV infection," or notes that "because of her previous IV drug use, client is at risk for HIV infection" — that information is likely protected because it could reasonably identify the client as having an HIV-related condition.

c. RULE OF THUMB

When in doubt, treat as protected by Article 27-F any information that might identify an individual — or his/ her contact — as having been tested for or diagnosed with an HIV-related condition.

2. WHAT INFORMATION IS PROTECTED BY HIPAA

Unlike Article 27-F, which only protects HIV-related information, HIPAA protects all **"individually identifiable health information"** held or transmitted by a **"covered entity"** (which includes health care providers, health plans, and health care clearinghouses; see page 35). This information is known as **"protected health information"** ("PHI").

"Individually identifiable health information" is health information created or received by a covered entity, and which relates to:

- a past, present, or future physical or mental health condition of an individual;
- the provision of health care to the individual; or

- payment for the provision of health care to an individual,

and that identifies or reasonably could be used to identify the individual.[105] There are no restrictions on the use or disclosure of de-identified health information.[106]

F. WHO MUST COMPLY

1. WHO MUST COMPLY WITH ARTICLE 27-F'S CONFIDENTIALITY REQUIREMENTS

Article 27-F's confidentiality requirements apply to any person or agency who obtains HIV-related information either:

- in the course of providing one or more "health or social services" (as defined below) to individuals, or
- pursuant to a proper, HIV-specific release form authorizing the disclosure of confidential HIV-related information.[107]

a. PROVIDERS OF COVERED HEALTH OR SOCIAL SERVICES

"Health or social services" covered by this law include a wide range of health and social services provided by public and private individuals and organizations in New York, including:

- any kind of care or treatment, clinical laboratory tests, counseling services for adults or children, educational services for adults or children, and home care or health care (including acute, chronic, custodial, residential, and outpatient care) services provided pursuant to the Public Health Law or Social Services Law;
- "public assistance or care" as defined in Article I of the Social Services Law, which includes Medicaid, various forms of welfare, institutional care for adults, and publicly funded child care;
- employment-related services, housing and shelter services, foster care, protective services, day care, and preventive services that are provided pursuant to the Social Services Law;
- services for individuals with mental disabilities, which, as defined in Mental Hygiene Law § 1.03(3)), include mental illness, retardation, developmental disabilities, alcoholism and substance dependence; and
- criminal justice services: probation, parole, correctional, and detention services and rehabilitative services for youth provided under laws dealing with aspects of the state's criminal and juvenile justice systems.[108]

All agencies providing these health and social services — including ALL staff and volunteers — must comply with Article 27-F's confidentiality requirements. So must health care providers that are associated with or under contract to health maintenance organizations (HMOs) or other medical services plans.[109]

[105] 45 C.F.R. § 160.103.
[106] 45 C.F.R. §§ 164.502(d)(2), 164.514(a) and (b).
[107] N.Y. Pub. Health Law § 2782.
[108] N.Y. Pub. Health Law § 2780(8).
[109] N.Y. Pub. Health Law § 2784.

b. THOSE WHO RECEIVE HIV-RELATED INFORMATION PURSUANT TO RELEASE

People and agencies (whether or not they provide any of the "health or social services" just described) must comply with the law's confidentiality requirements when they get HIV-related information pursuant to a proper HIV-specific release form (see page 36).

c. GOVERNMENTAL AGENCIES AND EMPLOYEES

State and local government. Article 27-F's confidentiality requirements apply to state and local governmental agencies and their employees when they obtain HIV-related information about individuals in the course of providing health or social services under a government program, or in the course of monitoring other providers of such services to individuals, or when they obtain such information pursuant to a proper release form.[110] State and local Health Departments and public health staff must also comply with the confidentiality requirements of the HIV Reporting and Partner Notification Law in handling any information about people with HIV/AIDS and their contacts pursuant to that law (see pages 51-60).

Federal government. State laws, including Article 27-F, cannot directly control federal agencies, such as the Social Security Administration (which administers disability benefits), or the Veterans Administration. However, Article 27-F's confidentiality requirements do apply to most providers who may be asked to disclose HIV-related information about their clients to those federal agencies and their employees.

Also, any individual in New York — including federal employees — who receives HIV-related information in accordance with the requirements of Article 27-F must comply with the law's restrictions on disclosure and re-disclosure.[111] This means that if a case worker at the Social Security Administration (not generally covered by the law) receives HIV-related information about an applicant for disability benefits from a physician (who is covered by the law), that case worker may not re-disclose that information unless authorized by Article 27-F.

Note that Article 27-F does not apply to the military or to federal prisons.

d. AGENCIES WITH CERTAIN STATE CONTRACTS

Agencies that are not "health or social service providers" may nonetheless be required to comply with Article 27-F's mandates through contract with the state or local government.

Many community-based HIV/AIDS service providers are not included in Article 27-F's definition of covered "health or social service" providers. Only information they obtain pursuant to HIV-specific release form would be protected by the law. To make sure that they and their staff protect their clients' confidentiality, organizations funded through the Department of Health AIDS Institute may be required to adhere to the law's mandates as a term of their state contracts. While confidentiality violations might not subject these agencies to the penalties specified in Article 27-F (see pages 82-85), they would place them in breach of contract with the AIDS Institute.

[110] N.Y. Pub. Health Law §§ 2782(6); 2786.
[111] N.Y. Pub. Health Law § 2782(3).

e. RECIPIENTS OF ARTICLE 27-F'S "NOTICE PROHIBITING RE-DISCLOSURE"

Anyone who receives a "notice prohibiting re-disclosure" of HIV-related information (see pages 41-42) must adhere to Article 27-F's mandates.

f. ANYONE WHO RECEIVED HIV-RELATED INFORMATION PURSUANT TO ARTICLE 27-F

Anyone to whom confidential HIV-related information was disclosed pursuant to Article 27-F is prohibited from re-disclosing the information unless authorized by that law, except if the disclosure was to:

- the protected individual (or person authorized by law to consent to the protected individual's health care);
- the protected indvidual's foster parent or other relative or legally responsible person with whom a child is to be placed when the disclosure is for the purpose of providing care, treatment, or supervision of the child (see page 65);
- a prospective adoptive parent with whom the protected individual has been placed for adoption.[112]

This means that even if Article 27-F does not require sending a notice prohibiting re-disclosure in a given circumstance, the recipient of confidential HIV-related information is nonetheless bound by Article 27-F unless the recipient falls into one of the three categories listed above.

2. WHO DOES NOT NEED TO COMPLY WITH ARTICLE 27-F'S CONFIDENTIALITY REQUIREMENTS

a. PROTECTED INDIVIDUALS THEMSELVES

A "protected individual" — the one who has been tested for or diagnosed with HIV/AIDS — is free to disclose his/her own HIV-related information.[113]

b. PEOPLE AUTHORIZED TO ACT ON THE PROTECTED INDIVIDUAL'S BEHALF

When a protected individual lacks "capacity to consent" to disclosures of HIV-related information (see page 39), a person who is legally authorized to consent to health care for that individual may freely disclose HIV-related information about that individual to anyone else.[114] The only people likely to fit this description are:

- the parent(s) of a minor who lacks capacity to consent,
- the legal guardian of such a minor or of an individual adjudicated as incompetent,
- an individual's health care "agent" named in a health care proxy (see page 11), or
- a surrogate per the Family Healthcare Decisions Act[115] (see page 11).

But only "natural persons" are covered under this rule. For example, an agency, such as the local child welfare agency, may be appointed as the legal guardian of a child in

[112] N.Y. Pub. Health Law § 2782(3).
[113] N.Y. Pub. Health Law § 2782(3)(a).
[114] N.Y. Pub. Health Law § 2782(3)(b).
[115] N.Y. Pub. Health Law Art. 29-CC.

foster care, and may be given legal authority to consent to health care for that child. But, because a child welfare agency is not a "natural person," it remains subject to Article 27-F's confidentiality and disclosure requirements. The special rules that apply to foster parents and prospective adoptive parents are explained below (see pages 64-68).

3. OTHERS NOT SUBJECT TO THE LAW

a. FRIENDS, FAMILY AND OTHER NATURAL PERSONS

The law's confidentiality requirements do not apply to natural people — like an individual's parents or friends — who get HIV-related information about a person directly from that person, or from someone else who got the information in a way other than in the course of providing health or social services to the individual or others, or pursuant to an HIV-specific release form. For example:

- An HIV positive man (John) tells his sexual partner his HIV status. The sexual partner tells John's parents. Article 27-F does not apply to the sexual partner or the parents.
- A woman with HIV infection (Mary) tells her sister her diagnosis. Article 27-F does not apply to Mary's sister. If she re-discloses Mary's HIV status to others, she would not be violating Article 27-F.

b. JUDICIARY

Article 27-F's confidentiality requirements do not apply to courts (that is, to judges), and may not apply to court employees (such as court officers and clerks). However, virtually all health or social service providers and other individuals who may be asked to disclose HIV-related information to the courts are subject to the law.

c. POLICE

Article 27-F's confidentiality requirements do not apply to the police, but Constitutional privacy protections do apply to the police and other government agencies.

d. SCHOOLS

Public and private school personnel generally are not covered by Article 27-F, unless HIV-related information comes to particular school staff in the course of providing a covered health or social service or through release. The following school staff are covered:

- Health staff, such as the school nurse or mental health or drug/alcohol counselor, who get HIV-related information in the course of providing a student "health services" within the law's definition.

  For example, if a mother informs the school nurse that her daughter needs to take HIV medications during the school day, the nurse is bound by Article 27-F's confidentiality requirements because the nurse received the information while providing health services to the daughter.
- Any school staff who get HIV-related information pursuant to a proper HIV release form (such as a school nurse, health clinic, principal, or teacher).

Note: Constitutional privacy protections apply to public schools and their employees, even if Article 27-F does not apply.

e. EMPLOYERS

Employers are not covered by Article 27-F, except when they obtain HIV-related information about an employee pursuant to an HIV-specific release form. But many employers are bound by the confidentiality provisions of the federal Americans with Disabilities Act (see pages 98-99).

f. LANDLORDS

Except for those who provide housing and shelter services regulated by the Social Services Law — who are defined as covered "social services" providers — landlords are not subject to Article 27-F's confidentiality requirements unless they received HIV-related information about a housing applicant or tenant pursuant to an HIV-specific release form. Landlords who learn about a tenant's HIV status from the tenant or neighbors are not covered by Article 27-F. But Constitutional privacy protections apply to public (governmental) housing providers.

g. NEWSPAPERS AND OTHER MEDIA

h. CHURCHES AND OTHER HOUSES OF WORSHIP

i. SOME HEALTH AND SOCIAL SERVICE PROFESSIONALS

Professionals who do not work in one of the covered health or social services, or who get HIV-related information when off duty (not in connection with their work) are not covered. They are bound by Article 27-F only if they got the information pursuant to an HIV-specific release form. However, they may be covered by HIPAA or another confidentiality law (see page 25).

j. INSURANCE COMPANIES

Just as insurance companies are subject to special, less stringent rules with respect to HIV testing (see pages 5 and 22-23), Article 27-F's general confidentiality and disclosure rules do not apply to insurance companies or "insurance support organizations" (like the Medical Information Bureau, noted at page 5).[116] Managed care organizations and health maintenance organizations (HMOs), however, are considered "insurance institutions"[117] and "health care providers")[118] under Article 27-F, according to the New York State Department of Health. Therefore, they need to comply with Article 27-F's general confidentiality requirements.

[116] N.Y. Pub. Health Law §§ 2782(1)(i); 2784.
[117] N.Y. Pub. Health Law § 2780(16).
[118] N.Y. Pub. Health Law § 2782(13).

4. WHO MUST COMPLY WITH HIPAA'S CONFIDENTIALITY REQUIREMENTS

a. COVERED ENTITIES

All **"covered entities"** under HIPAA must comply with its Privacy Rule. A covered entity is:

- a health care provider who transmits any health information electronically in connection with specified covered financial and administrative transactions;[119]
- a health plan (plan that provides, or pays the cost of, medical care); or
- a health care clearinghouse (entity that processes and/or facilitates the processing of health information from another entity).[120]

HIPAA's privacy requirements do not apply to entities that are *not* "health care providers," "health plans" or "health care clearinghouses" as defined by HIPAA. While both "health and social service" providers must comply with Article 27-F, only those who are "health care providers" under HIPAA must comply with HIPAA.

[119] Examples of covered transactions include processing claims, payment and remittance, coordination of benefits, claim status, enrollment and dis-enrollment in a health plan, health plan eligibility, health plan premium payments, referral certification and authorization, first report of injury, and health claims attachments. 45 C.F.R. § 160.103.

[120] 45 C.F.R §§ 160.102(a); 160.103; 164.104.

II. DISCLOSURES WITH CONSENT

A. THE RULE: CONSENT (IN AN HIV-SPECIFIC RELEASE FORM) REQUIRED

A person or agency that is subject to Article 27-may disclose HIV-related information about a protected individual who has signed a proper **written** release specifically authorizing that disclosure (or, if the individual lacks capacity to consent, a person authorized to consent to health care for that individual has signed the release form).[121] Oral consent does not authorize disclosures under Article 27-F. All such release forms must be:

- voluntarily signed and revocable at any time; and
- in proper form, with all elements required by Article 27-F.[122]

B. HIV-SPECIFIC RELEASE: REQUIRED ELEMENTS

Under Article 27-F, the HIV-specific release form must contain 8 elements to be valid:

- specific authorization to disclose **HIV-related information**;
- **name** of the person whose HIV-related information will be disclosed;
- **name** of the person/agency disclosing the HIV-related information;
- name of the **recipient** of the HIV-related information (see explanation on page 38);
- **reason** for the disclosure;
- **date** the release form is signed;
- **time period** during which the consent will remain in effect:
    - » the consent should not last longer than necessary to fulfill its purpose;
    - » the release can specify that it will remain in effect until a certain date (e.g., May 10, or "10 days after the date of this release"), or until the occurrence of a specified event or condition ("This release will remain in effect until the date I stop receiving case management services from ABC Services.");
    - » the Department of Health recommends that releases be renewed at least annually; and
- **signature** of the person whose HIV-related information will be released or, if that person lacks capacity to consent, signature of the person authorized to consent for that individual (see pages 39-41).[123]

[121] N.Y. Pub. Health Law § 2782(1)(a).
[122] N.Y. Pub. Health Law §§ 2780(9); 2786; 45 C.F.R § 164.508(b).
[123] N.Y. Pub. Health Law § 2780(9).

If an organization is covered by HIPAA, the release (which is called an "authorization" under HIPAA) must have an additional 2 elements:

- an explanation of the patient's **right to revoke** the authorization in writing and either a statement of the exceptions to the right to revoke, or, if the exceptions are included in the program's notice of patient's privacy rights, a reference to that notice;[124] and
- a statement of the provider's **ability to condition treatment, payment, enrollment, or eligibility for benefits** on the consent (this must state either that the program may not condition services on the patient signing the consent or the consequences of refusing to sign the consent if the program may condition services on such signature).[125]

The State Department of Health has developed two model forms that comply with both Article 27-F and HIPAA. The "Authorization for Release of Health Information and Confidential Related HIV-Related Information" (see Appendix E) can authorize the disclosure of HIV and non-HIV health information. The"Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information" (see Appendix F) also can authorize the release of alcohol/drug treatment and mental health information. These forms also can be found on the website of the Department of Health, AIDS Institute, http://www.health.ny.gov/diseases/aids/forms/. Other state agencies have developed forms for use by providers funded or regulated by those agencies.

Although providers may develop other HIV-specific release forms for use by their staff, all release forms must contain information consistent with the Department of Health's standardized model forms.

C. GENERAL RELEASES NOT SUFFICIENT; SUBPOENAS NOT SUFFICIENT

A general release form authorizing disclosures of medical or other information about a pro-tected individual is not sufficient to authorize a disclosure of HIV-related information — unless that release form specifically indicates its dual purpose as a general authorization and a specific authorization for the release of confidential HIV-related information, and complies with Article 27-F's requirements, set out above.[126] The only exception is for certain disclosures to insurers (see page 69).

A subpoena, by itself, neither permits nor compels any person or organization to release confidential HIV-related information.[127] To permit disclosures, a subpoena must be accompanied by either a proper HIV-specific release form or a special court order issued in compliance with Article 27-F (see pages 70-72).

[124] 45 C.F.R. § 164.508(c)(2)(i).
[125] 45 C.F.R § 164.508(c)(2)(ii).
[126] N.Y. Pub. Health Law § 2780(9).
[127] N.Y. Pub. Health Law § 2782(1).

D. PRACTICAL POINTERS FOR HIV-SPECIFIC RELEASE FORMS

1. DESCRIBING RECIPIENTS: GENERAL OR SPECIFIC?

Article 27-F requires an HIV-specific release form to "specify to whom disclosure is authorized."[128] Thus, a general designation of a recipient — e.g., to "possible housing providers," or to "anyone who may be assigned to provide me home care" – does not satisfy the law's requirements. On the other hand, it would be permissible to ask a client to authorize disclosures by the agency to "any of the five housing providers listed below."

It is permissible to name an agency or organizational unit, provided that the whole organization (or unit) needs the HIV-related information to carry out the purposes specified in the release. A release form identifying a local Department of Social Services ("DSS") as the recipient, when only one unit or program within the DSS needs the information, is not permissible. Alternatively, the form can list the job title of pertinent staff who need the information, such as "my DSS caseworker" or "those DSS employees working on my case." The form does not have to list such individuals by name.

2. REVOCATION OF CONSENT

Under both Article 27-F and HIPAA, individuals have the right to revoke their consent to disclose HIV information at any time, for any reason. The revocation prevents the provider from making any further disclosure in reliance on that release form.

Under Article 27-F, individuals may revoke their consent orally or in writing. (Though HIPAA requires revocation of an authorization to be in writing,[129] Article 27-F's "more stringent" provision applies.) Under Article 27-F, individuals do not have to use special language to revoke an HIV-specific release. For example, if a person who has previously signed a release form tells the provider, "I've changed my mind," or "I take back my release," those statements both operate as revocations of the release.

An individual's decision to revoke his/her consent must be documented in the client's record in a way that will ensure that all staff are aware of it. This can be done by a dated, large notation on the release form itself, or a visible notation elsewhere, such at the front of the client's chart. If HIV-related information has already been released, the person or agency that made the disclosure does not have an obligation to retrieve the information. However, individuals have a right to be informed, upon request, of any disclosures that have been made;[130] and agencies should be prepared to respond to such requests (see page 77).

[128] N.Y. Pub. Health Law § 2780(9).
[129] 45 C.F.R § 164.508(c)(2).
[130] N.Y. Pub. Health Law § 2782(5)(b).

E. CAPACITY TO CONSENT TO DISCLOSURES

1. WHAT IS "CAPACITY TO CONSENT"?

Any individual who has "capacity to consent" generally has the right to decide whether to allow or forbid disclosures of HIV-related information about him/herself. Article 27-F defines "capacity to consent" in the same way for disclosure decisions as for HIV testing decisions[131] (see pages 2, 5-11). Thus, each individual's capacity must be determined, without regard to age, by conducting an individualized assessment that asks:

1. Is this person able to understand and appreciate the nature and consequences of the proposed disclosure? That is, does the person understand:
    - "what is going to be disclosed, to whom and why?"
    - "what might happen (good and bad) as a result of this disclosure?"

2. Is this person able to make an informed decision about whether to permit it? That is —
    - "am I making this decision voluntarily, or is someone forcing me?"

If both answers are yes, the individual's capacity to consent must be recognized, and his/her disclosure decision must be respected. The fact that an individual may have a mental or physical disability does not automatically determine capacity to consent.

If the answer to either question is no or doubtful, then those with responsibility for assessing the individual's capacity should either:

- **determine whether someone else is legally authorized** to consent to health care for that individual, identify that person, and decide whether to contact that person to obtain his/her consent to the disclosure (see Sections 3-6, below);
- **defer the disclosure** until the protected individual (re)gains capacity to consent; or
- determine **whether the disclosure can be made without the individual's consent** (see exceptions in section III).

Guidelines for assessing capacity in particular situations, including those involving minors and people with impairments, are discussed below.

2. WHO ASSESSES CAPACITY?

As with HIV testing, Article 27-F does not specify who should assess particular individuals' capacity to consent to disclosures. Nor does it require this assessment to be done by medical or mental health specialists. It makes sense for health and social service agencies to presume that most clients — adults and even adolescents — do have the capacity, and therefore the right, to make disclosure decisions about themselves. At the same time, providers should designate the staff responsible for making such assessments when questions arise in a particular case.

[131] N.Y. Pub. Health Law § 2780(5).

3. INFANTS AND VERY YOUNG CHILDREN

a. DO THEY HAVE CAPACITY TO CONSENT?

Infants and very young children will not have capacity because they will not be able to satisfy the two-part test above.

b. WHO MAY CONSENT ON THEIR BEHALF?

When a child lacks capacity, it is permissible to seek consent for disclosure from a person legally authorized to consent to health care for the minor.[132] These persons are as follows:

Intact families. The birth parents ordinarily have legal authority to consent to health care — and so to HIV-related disclosures — for the child.[133]

Foster care. Foster parents themselves may disclose HIV-related information about their own foster child "for the purpose of providing care, treatment or supervision" of the child; they do not need anyone's consent.[134] However, foster parents do not have the legal authority to give effective consent for others to disclose HIV-related information about their foster child. Consent for these disclosures must be obtained from the person(s) with legal authority to consent to health care for the foster child: either the child's birth parent (in cases of voluntary placement) or the local social services commissioner (when the commissioner has guardianship or protective custody of the child). (See also pages 6- 8.)

Adoption. Once an adoption is finalized, the adoptive parents generally assume all parental rights; they thus have legal authority to consent to HIV-related disclosures. In addition, a prospective adoptive parent with whom a child has been placed for adoption is authorized to disclose HIV-related information about that child, without restriction and without obtaining the consent of anyone else.[135] However, until adoption becomes final, the rules applicable to children in foster care govern disclosures by persons other than the prospective adoptive parents. (See also page 8.)[136]

4. OLDER CHILDREN AND ADOLESCENTS (UNDER AGE 18)

Minors (under age 18) may and often do have the capacity to consent to disclosure of HIV-related information about themselves. For older children or adolescents, providers must assess that particular individual's capacity to consent as described on pages 40-41.

If the older minor has capacity to consent to disclosure and declines to give it, no disclosure may be made, unless —

[132] N.Y. Pub. Health Law § 2781(1).

[133] N.Y. Pub. Health Law § 2504(2).

[134] N.Y. Pub. Health Law § 2782(3)(c).

[135] N.Y. Pub. Health Law § 2782(3)(d).

[136] These rules are explained in an administrative directive issued by the former State Department of Social Services (now the State Office of Children and Family Services), entitled *Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure*, 97 ADM-15 (July 24, 1997) ("OCFS 97 ADM-15"). The New York City Administration for Children's Services also has issued a bulletin on the subject, Bulletin 98-2/Procedure 101, *HIV Related Assessment, Testing, Counseling and Clinical Trial Enrollment of Children and Youth in Foster Care* (December 30, 1998). That agency's Pediatric AIDS Unit handles questions about HIV-related disclosures concerning foster care children (212-341-8943).

- that child is in foster care and the disclosure is required under rules for children in foster care (see pages 64-68); or
- Article 27-F allows the disclosure without consent. (See pages 49-51 regarding notifying parents about a minor's HIV status, and pages 70-72 regarding court- ordered disclosures.)

5. INDIVIDUALS WHO HAVE BEEN ADJUDICATED INCOMPETENT

a. DO THEY HAVE CAPACITY?

As with HIV testing (see page 10), a person who has been judicially declared incompetent to make health care decisions will not have the capacity to consent to disclosures of HIV-related information.

b. WHO MAY CONSENT ON THEIR BEHALF?

The person appointed as the individual's legal guardian may be given the authority to make health care decisions including the right to consent to HIV-related disclosures.

6. INDIVIDUALS WITH TEMPORARY INCAPACITY

a. DO THEY HAVE CAPACITY?

Sometimes, a person will lack capacity to consent to a disclosure of HIV-related information because of conditions that temporarily impair the person's cognitive abilities or judgment, or because of other physical or mental conditions. For example, a client might be intoxicated or under the influence of drugs, experiencing stress or other psychiatric problems, unconscious or comatose. In these circumstances, the provider may wish to defer making the disclosure.

b. WHO MAY CONSENT ON THEIR BEHALF?

In these cases, if the individual has a health care proxy in place, consent may be sought from the health care agent (see page 11). Alternatively, in a hospital or nursing home, a "surrogate" selected pursuant to the Family Health Care Decisions Act can provide consent (see pages 11-12).[137]

F. NOTICE PROHIBITING RE-DISCLOSURE

Article 27-F generally requires that when any disclosure is made pursuant to this law, including disclosures made pursuant to consent, the disclosure shall be accompanied by a "notice prohibiting re-disclosure,"[138] which informs the recipient that it is now bound by Article 27-F and may not re-disclose HIV-related information without consent or as otherwise permitted by law (see Appendix G).[139] The notice does *not* need to be sent, however, when the disclosure is:

[137] N.Y. Pub. Health Law, Art. 29-CC.
[138] N.Y. Pub. Health Law § 2782(5)(a).
[139] N.Y. Pub. Health Law § 2780(9).

- to a health care provider and is necessary for the care or treatment of the individual or the individual's child;
- to a third party for health care reimbursement;
- to the protected individual;
- by a physician conducting contact notification; or
- by a physician to the parents of a minor.

(All of these disclosures are discussed in greater detail in Section III). Therefore, when any provider is disclosing HIV-related information pursuant to consent, the provider should send the notice prohibiting re-disclosure unless one of the five circumstances above, applies. The notice prohibiting re-disclosure must accompany any written disclosures and must follow oral disclosures within 10 days.[140]

[140] N.Y. Pub. Health Law § 2782(5)(b).

III. DISCLOSURES WITHOUT CONSENT

Article 27-F and HIPAA permit the disclosure of confidential HIV-related information without consent in a limited number of circumstances. These "exceptions" fall into the following basic categories:

- Protected individuals
- Internal communications among authorized staff
- Health care providers/facilities (when necessary for care)
- Physicians' disclosures about minors and incompetent adults to their parents or guardians
- HIV/AIDS case reporting
- Contact reporting and notification
- Newborn HIV test results
- Occupational exposure
- Foster care or adoption
- Insurers
- Court-ordered disclosures
- Program monitoring, evaluation or review
- Medical education, research or therapy
- Criminal justice-related disclosures
- Child abuse/neglect and elder abuse/neglect
- Administrators and executors of estates

A. PROTECTED INDIVIDUALS

1. DISCLOSURES TO INDIVIDUALS ABOUT THEMSELVES

Health and social service agency staff may disclose HIV-related information to the protected individual him/herself without consent. When the client lacks capacity to consent, disclosures may be made to a person authorized by law to consent to health care for the client. In such cases, providers must confirm that the person to whom they make a disclosure is in fact "authorized by law to consent to health care for that individual."[141] (This problem arises primarily in cases of disclosures about a minor; see pages 6-10.)

Providers should be careful to ascertain whether the client already knows or wants to know his/her HIV status before launching into discussions with that client about his/her diagnosis. As noted previously (see page 16), individuals have the right not to know their HIV-related diagnosis.

[141] N.Y. Pub. Health Law § 2782(1)(a); 45 C.F.R. § 164.524; *see also* 45 C.F.R. § 164.510(a)(3).

2. DISCLOSURES BY INDIVIDUALS ABOUT THEMSELVES

Any individual with HIV may inform any other person about his/her own HIV status.[142] However, providers should counsel their clients about the possible consequences of such disclosures. For example, because the client's friends and family are not bound by Article 27-F or HIPAA, they could re-disclose this sensitive information to anyone, and the client would have no remedy under the HIV confidentiality law.

B. INTERNAL COMMUNICATIONS

1. THE RULE

Internal Communications

Authorized employees of a health or social service provider may share confidential HIV-related information about their clients within their agency, without consent, *if* they:

- are on agency's written "need to know" list, and
- reasonably need the information to provide services.

2. WHO COMES UNDER THE INTERNAL COMMUNICATIONS RULE

The internal communications rule applies to:

- providers of health or social services who are subject to Article 27-F (listed on page 30), including health care facilities and providers listed on page 46; and
- state and local governmental agencies that become subject to Article 27-F (see page 31).

3. WHICH "INTERNAL COMMUNICATIONS" ARE ALLOWED

The internal communications rule allows employees of an entity that is covered by Article 27-F to have access to and share confidential HIV-related information about clients without their consent **if those employees:**

- are **allowed access to client records** in the ordinary course of business (this means medical records for health care providers and facilities; client records for other health or social services);
- are specifically authorized **in the agency's written "need-to-know" protocol** to have access to HIV-related information about the clients in question (the regulations implementing Article 27-F require all covered health and social service providers to have "need-to-know" protocols); and
- have a **reasonable need** to know or share the information **to carry out their authorized duties** in providing, supervising, administering or monitoring the services.[143]

[142] N.Y. Pub. Health Law § 2782(3).
[143] N.Y. Pub. Health Law §§ 2782(1)(c); 2782(6)(b); and 2786(2).

4. HOW COVERED AGENCIES CAN CREATE A NEED-TO-KNOW PROTOCOL

Although Article 27-F does not specify which employees belong in the need-to-know circle, the law does require providers to establish protocols specifying which employees have access to confidential HIV-related information.

Covered agencies should take the following steps to create and implement their policies:

a. CONDUCT AN AGENCY-SPECIFIC ASSESSMENT

Assess which staff legitimately need to have or share HIV-related information about clients.

Permissible reasons include:

- providing direct care/services to the clients;
- performing administrative, billing or reimbursement functions;
- planning, coordinating or supervising services to clients (for example, when staff work in "teams").

Impermissible reasons include:

- "infection control" – as discussed in on page 47, staff are not entitled to learn a client's HIV status solely for the purpose of protecting themselves from potential exposure to HIV;
- belief that employees have a "right to know" (they do not). HIV-related information may not be shared to satisfy employees' curiosity.

b. CREATE A WRITTEN NEED-TO-KNOW PROTOCOL

The protocol should describe who may have or share HIV-related information on a need-to-know basis by:

- listing the job titles of those with authorized access, and
- describing the functions of each job that justify having and sharing HIV-related information.

c. DISSEMINATE THE PROTOCOL AND TRAIN STAFF

Give the protocol to all staff, not just those on the need-to-know list.

Internal communications of HIV-related information under this exception need not be noted in the client's record. Nor is the notice prohibiting re-disclosure required (see page 41).

HIPAA also requires covered entities to make reasonable efforts to limit the information shared internally to "the minimum necessary to accomplish the intended purpose."[144]

Section IV (pages 76-81) contains more information about how to record and maintain HIV-related information securely.

[144] 45 C.F.R. § 164.502(b)(1).

C. DISCLOSURES TO HEALTH CARE PROVIDERS AND HEALTH FACILITIES

1. THE RULE

Health Care Provider Rule

HIV-related information may be disclosed, *without consent,* to a health care provider or facility when:

- knowing it is necessary for that provider to give appropriate care or treatment to –
  - the protected individual,
  - his/her child, or
  - a contact of the protected individual.

2. HEALTH CARE PROVIDERS AND HEALTH FACILITIES COVERED BY THIS EXCEPTION

Disclosures without HIV-specific consent may be made to "health care providers" and "health facilities" in certain situations, as discussed at pages 47-49, below.[145]

"Health facilities" include:

- hospitals,
- blood, sperm, organ and tissue banks,
- laboratories, and
- facilities providing care or treatment to persons with a "mental disability"—including mental illness, mental retardation, developmental disabilities, alcoholism or substance dependence.[146]

"Health care providers" include:

- physicians,
- nurses,
- providers of services for persons with "mental disabilities" (as defined above),
- other medical, nursing, counseling, health or mental health care service providers, including those associated with health maintenance organizations and medical service plans, and
- licensed or certified providers of diagnostic medical services, including nurse practitioners, midwives and physician assistants.[147]

This exception, therefore, authorizes unconsented-to disclosures to a fairly broad array of health and mental health facilities and providers (hereafter "health care providers"). At the same time, the disclosures can only be made in certain circumstances, discussed below.

This exception does not permit disclosures to institutions or persons who are not included within the above definition of "health care providers" and "health facilities" — such as day care facilities, schools, housing and many other social service providers.

[145] N.Y. Pub. Health Law § 2782(1)(d).
[146] N.Y. Pub. Health Law § 2780(12); N.Y. Mental Hyg. Law § 1.03(3).
[147] N.Y. Pub. Health Law § 2780(13); 10 N.Y.C.R.R. § 63.1(j).

3. WHEN KNOWING HIV INFORMATION IS "NECESSARY" FOR CARE

As highlighted in the "rule" box, above, a health care provider may be given HIV-related information about an individual when it is necessary for that health care provider (or one or more of its employees) to know the client's HIV status or related diagnosis in order to provide appropriate care to that client, her child, her contact (or a person authorized to consent to health care for the contact) (see page 27 for definition of "contact), or an occupationally exposed individual (see pages 62-64.[148] HIPAA also permits these disclosures.[149]

a. APPLYING THE STANDARD

Article 27-F does not specify when a health care provider/facility must be given HIV-related information about an individual in his/her care. This must be assessed on a case-by-case basis.

i. DISCLOSURES FOR "INFECTION CONTROL" NOT ALLOWED

Under standards developed by the State Department of Health, it is not necessary — and not permissible — to disclose an individual's HIV status to a health care provider solely for "infection control" purposes, i.e., to protect health care workers from possible exposure to HIV.[150]

This is because casual contact creates no risk of HIV transmission, and health care workers and others can effectively minimize their risk of occupational exposure through universal infection control precautions that must be in place regardless of whether a particular individual's HIV status is known. Article 27-F regulations require health care providers to develop and implement universal infection control protocols, and to educate their employees about and monitor compliance with them. If health care providers only take precautions when they know a patient is infected, they are putting themselves at unnecessary risk.

ii. NO GENERAL "RIGHT TO KNOW"

Some providers believe that they have a "right to know" the HIV status of their patients, either because they wish to take additional infection control precautions for those known to be infected, or because they assume they always need this information to treat individuals. They have no such legal right, though. Nor do patients (or their providers) have a legal obligation to tell health care providers their HIV status.

iii. EXAMPLES

- **EMS.** Jan, who is HIV-positive, is at her HIV case management office where she falls unconscious, hits her head, and bleeds. The case management office calls emergency medical services (EMS), and EMS asks about Jan's medications. May the case management office tell EMS about Jan's HIV medications or her HIV status?

  Yes. The agency may tell EMS about Jan's HIV medications and her HIV status so that EMS can provide the appropriate care to Jan en

[148] N.Y. Pub. Health Law § 2782(1)(d).
[149] 45 C.F.R. § 164.506(c).
[150] 10 N.Y.C.R.R. § 63.6(j).

route to the hospital, and convey the information to the hospital upon arrival. If Jan were conscious, the agency could permit her to make her own disclosure.

- **Referral to Specialist.** Sam has seen a primary care physician since his HIV diagnosis three years ago. His primary care physician now plans to refer him to a specialist. Does the physician's office need an HIV-specific release form to disclose Sam's HIV status to the specialist?

  No. The primary care physician may disclose Sam's HIV-related information to the specialist because it is necessary for the specialist to provide appropriate care and treatment to Sam.

4. WHO DECIDES WHETHER A DISCLOSURE IS "NECESSARY" FOR THE PATIENT'S CARE?

The provider or individual in possession of the confidential HIV-related information — not the outside health care provider requesting the confidential HIV-related information — has the discretion to decide whether the requesting provider really needs to know the client's HIV status to appropriately treat or care for that individual (or his child or contact). A health care provider cannot compel any other agency to make such a disclosure if that agency chooses not to do so.

It makes sense for health and social service agencies to designate the specific staff members with responsibility for deciding, on a case-by-case basis, when and to whom unconsented-to disclosures may be made. If the agency does not have medical staff, making such judgments obviously can be difficult. The designated staff person must use his/her best judgment.

5. SHOULD PROVIDERS ASK THE CLIENT TO SIGN AN HIV-SPECIFIC RELEASE ANYWAY?

The Department of Health recommends that when there is no emergency, community-based organizations should always seek consent from the client anyway before disclosing HIV-related information to outside health care providers. This is so even when the outside provider may need that information in order to provide the client appropriate care or treatment.

6. LIMITING DISCLOSURES TO AUTHORIZED STAFF

People making disclosures under this exception must be careful about the person(s) to whom they disclose confidential information. The only employee(s) of a health care provider or facility who may be given HIV-related information under this exception are those who –

- are authorized (under the health care provider's written "need to know" protocol) to have access to medical records, and
- provide health care to the subject of the information, or maintain the provider's medical records for billing or reimbursement purposes.

These criteria are more fully discussed in the Internal Communications section (page 44).

7. DOCUMENTATION

Any disclosure must be documented in the agency's medical records pertaining to the individual whose HIV-related information is disclosed (see page 76). The notice prohibiting re-disclosure (see page 41) does *not* need to be sent to the health care provider/facility receiving the information under this rule.[151]

D. PHYSICIANS' DISCLOSURES ABOUT MINORS AND INCOMPETENT ADULTS TO PARENTS/LEGAL GUARDIANS

Physicians (but no one else) may sometimes disclose HIV-related information about a minor, even without an HIV-specific release form, to a person who is authorized by law to consent to health care for the minor — usually the parent or legal guardian.[152] This special rule also permits physicians to make unconsented-to disclosures about persons who have been judicially declared incompetent to those who are authorized to consent to health care on the person's behalf — again, usually the parent or legal guardian. The discussion in this section focuses mainly on disclosures about minors because it is more common and often more controversial than disclosures about persons adjudicated incompetent.

1. THE RULE

Physician Disclosures to Parents/Guardians

Physicians may disclose HIV-related information about a minor child or incompetent adult to parents/legal guardians *if* physician reasonably believes:

- disclosure is medically necessary for timely care and treatment, *and*
- minor/incompetent adult will not inform parent/guardian, even after counseling about need for disclosure.

But *not* if, in physician's judgement:

- disclosure would not be in minor/incompetent's best interest, *or*
- minor/incompetent has authority to consent to own treatment

2. APPLYING THE RULE

Article 27-F does not impose any parental notification requirement on physicians or anyone else who learns of a minor's HIV status or related condition. Parents may, of course, be notified if their minor child signs an HIV-specific release form. Parents may also be given HIV-related information about an infant or a young child who lacks capacity to consent (see page 65).

For practical purposes, this rule only comes into play with older minors who have capacity to consent. In these cases, physicians who wish to make a disclosure should always first seek the minor's consent. But, except in the two circumstances explained below, a physician may tell parents HIV-related information about their minor child even without the minor's consent, when **the physician reasonably believes that both:**

[151] N.Y. Pub. Health Law § 2782(5).
[152] N.Y. Pub. Health Law § 2782(4)(e).

- The minor will not inform, even after being given appropriate counseling (which is required) about the need to inform the parent/guardian; **and**
- Informing the parents is necessary for care. Disclosure is permissible only if the physician makes a reasonable judgment that informing the parent(s) about the minor's HIV status is "medically necessary in order to provide timely care and treatment" to the minor.[153]

  If, for example, the physician does not believe that the minor needs treatment for a particular problem at the time, or believes that parental involvement is not needed to secure the needed treatment, the disclosure would not be warranted. The rule does not permit physicians to tell a minor's parents about his HIV status simply because they feel that parents should know.

  On the other hand, if parental consent is required to authorize a particular treatment (and the parent's knowledge of the minor's HIV status has a bearing on this), the law allows the physician's disclosure.

Two circumstances barring any disclosure. Even if both of the above conditions are satisfied, however, the law prohibits doctors from informing parents/guardians when, in the physician's judgment, **either:**

- Disclosure would not be in minor's best interests.[154] While Article 27-F does not explain when a disclosure would run counter to a minor's best interests, possible circumstances include —
  - » where there is a risk of domestic violence or adverse actions against the minor by the parent/guardian or others associated with them, or
  - » where the minor is a "street kid" who has no relationship with his parent/guardian, or is otherwise so alienated from them that contacting them would not facilitate appropriate care and treatment; or
- Minor has legal authority to consent to the care or treatment in question.[155] As explained previously, minors generally do not have the right to consent to their own health care; their parents or legal guardians do. In the following circumstances, however, minors do have the right to consent to their own health care:
  - » when the minor is married, a parent, or pregnant;
  - » in emergencies requiring immediate medical care; and
  - » when the minor seeks treatment for certain specific health problems, such as sexually transmitted diseases (see pages 8-9).

In these cases, physicians are forbidden from making any HIV-related disclosure to the minor's parents. (See also the discussion about minors and consent to treatment for HIV/AIDS, on page 9.)

[153] N.Y. Pub. Health Law § 2782(4)(e).
[154] N.Y. Pub. Health Law § 2782(4)(e)(A).
[155] N.Y. Pub. Health Law § 2782(4)(e)(B).

Similarly, HIPAA permits a health care provider to disclose health related information to the legal guardian or "personal representative" of a minor, but it also defers to State law.[156] Consequently, such disclosures may only be made within the limits prescribed by Article 27-F.

3. NO LIABILITY FOR NOT DISCLOSING

Article 27-F never obligates a physician to notify the parent/legal guardian. Physicians (and their employers or associated health care providers) may not be held liable for failing to disclose HIV-related information to a parent/guardian.[157]

4. DOCUMENTATION

A physician who makes a decision or takes action under this rule must document the reason(s) in the minor/incompetent person's medical record. However, the physician does not need to provide the notice prohibiting re-disclosure that must accompany most disclosures of HIV-related information (see page 41).[158]

E. HIV/AIDS CASE REPORTING

1. THE RULE

HIV/AIDS Case Reporting

Physicians and other diagnostic providers must report:

- each case of HIV infection, HIV-related illness, and AIDS upon initial diagnosis,
- name of person diagnosed, and
- name of contacts (sexual and needle sharing partners) known by or given to the provider.

2. WHAT MUST BE REPORTED

Under the HIV Reporting and Partner Notification Law, which took effect on June 1, 2000, each case of HIV infection (except those diagnosed through anonymous testing), HIV-related illness, and AIDS must be reported to public health authorities on forms developed by the Department of Health. The reports must include:

- **name** and address **of the individual with HIV disease**;
- diagnostic and other information about the case;
- name and address of contacts known to or provided to the reporter (see page 27 for definition of "contacts");
- information about partner notification efforts completed or planned for each identified contact; and
- information concerning the mandated **domestic violence screening**

[156] 45 C.F.R. § 164.502(g).
[157] N.Y. Pub. Health Law § 2783(3)(a).
[158] N.Y. Pub. Health Law §§ 2782(4)(e); 2782(5)(a).

required to be conducted with respect to each contact for whom notification is being considered.[159]

Upon receiving a case report, the Department of Health or local public health officials may follow up with the reporter and request additional information to enable them to monitor the HIV epidemic and facilitate contact notification when they determine that it is merited to protect the public health.[160]

3. WHEN THE REPORT MUST BE MADE

The report must be made upon "determination" or "diagnosis" of HIV infection, HIV-related illness, *and/or* AIDS, and upon periodic monitoring of HIV infection by laboratory tests.[161] The following must be reported:

- any antigen or antibody tests or combination of tests indicative of HIV infection;
- HIV nucleic acid (RNA or DNA) detection test results;
- all CD4 counts (unless the test is performed for non-HIV-related reasons); HIV subtype and antiviral drug resistance testing;
- certain other diagnostic tests that the Department of Health may determine indicate an HIV infection, HIV-related illness or AIDS;[162] and
- clinical diagnoses of AIDS-defining illnesses.

4. WHO MUST REPORT

Four categories of medical providers and entities are mandated case reporters:

- **physicians and other persons authorized to order diagnostic tests or make medical diagnoses — or their agents.** Diagnostic providers include physicians, nurse practitioners, physician assistants and midwives who are authorized to order diagnostic tests and make clinical diagnoses;[163]
- **laboratories** performing diagnostic tests for screening, diagnosis or monitoring of HIV infection;
- **medical examiners, pathologists, or coroners** when HIV testing is done to determine cause of death; and
- **blood and tissue banks and organ procurement organizations.**[164]

No one else is required to submit HIV case reports (or may, without the individual's consent). That includes counselors or other mental health providers who learn of the individual's HIV infection, public assistance and child welfare workers, employers, family members, etc. Doctors who are treating a patient with HIV, who are not the "diagnostic provider" making the initial diagnosis of HIV, HIV-related illness or AIDS, are not mandated to make HIV case reports.

[159] N.Y. Pub. Health Law §§ 2130, 2132; 10 N.Y.C.R.R. § 63.4.
[160] 10 N.Y.C.R.R. § 63.4(b).
[161] N.Y. Pub. Health Law § 2130; 10 N.Y.C.R.R. § 63.4.
[162] 10 N.Y.C.R.R. § 63.4(a)(4).
[163] 10 N.Y.C.R.R. § 63.1(k).
[164] N.Y. Pub. Health Law §§ 2130; 2132; 10 N.Y.C.R.R. § 63.4(a).

Anonymous testing. Results of tests performed at anonymous test sites will not be reported unless the tested person voluntarily decides to convert the test to a confidential one.[165] If an anonymously tested person decides to seek medical care, however, the physician or other diagnostic provider who confirms the HIV diagnosis must report.

5. WHO RECEIVES THE REPORTS

Cases must be reported to the State Department of Health, which must promptly forward them to designated local public health officials in the county/city where the protected person lives.[166]

6. CONFIDENTIALITY OF CASE REPORTS

State and local public health officials **must keep confidential** all reports and information they obtain in connection with case reporting and contact notification activities. They may only use the information to track the HIV epidemic or facilitate partner notification efforts (where merited to protect the public health); and other than re-disclosure to the protected individual, may only re-disclose this information as follows:

- within New York State: to other public health officials only if, in the public health official's judgment, the disclosure is necessary for monitoring the HIV/AIDS epidemic or to conduct notification activities (see page 56).
- outside New York State: contact names and locating information may be disclosed to public health officials in other states if necessary to notify the contact or for purposes of de-duplication, but the identity of the protected individual may not be disclosed.[167]

7. PENALTY FOR NOT REPORTING

A mandated reporter who fails to adhere to the HIV/AIDS case reporting law can be subject to civil fines and be required to comply with the law. Prior to April 1, 2014, the civil fine can be up to $2,000 per violation, and after April 1, 2014, can go up to $10,000 if the violation causes serious physical harm.[168] If the violation is "wilful," the mandated reporter could be criminally prosecuted for committing a misdemeanor and be subject to fines.[169]

[165] N.Y. Pub. Health Law § 2138; 10 N.Y.C.R.R. § 63.4(b).
[166] N.Y. Pub. Health Law § 2130; 10 N.Y.C.R.R. §§ 63.4(a), 63.8(a)(2).
[167] N.Y. Pub. Health Law §§ 2134; 2135; 10 N.Y.C.R.R. § 63.4(c).
[168] N.Y. Pub. Health Law § 12.
[169] N.Y. Pub. Health Law § 12-b.

F. CONTACT (PARTNER) REPORTING AND NOTIFICATION

1. THE RULE

Contact Reporting and Notification

Reporting: Mandated HIV/SIDS case reporters (physicians and other diagnostic providers) must report to public health officials

- names/other information about known contacts, and
- information about their own contact notification efforts.

Notification:

- Public health officials must notify contacts about possible exposure to HIV if they determine that notification is merited to protect public health.
- Physicians may notify contacts in certain circumstances, but are not obligated to.

Confidentiality: Name of infected individual may *not* be revealed during notification.

With the passage of the HIV Reporting and Partner Notification Law in 2000, the reporting of an infected patient's contacts by physicians and diagnosing providers became a mandatory part of HIV/AIDS case reporting, and partner notification efforts are required in certain cases. At the same time, the law safeguards the identity of the HIV positive person during the notification process, and is designed to ensure that notification not occur where it could result in domestic violence to the protected individual or contact. HIPAA permits health care providers to comply with all state partner notification laws.[170]

2. REPORTING OF CONTACTS

a. WHAT IS A "CONTACT"?

"Contacts" (or "partners") are a protected individual's identified:

- spouse (present or past, dating back 10 years);
- sexual partners (dating back 10 years); and
- needle sharing partners.[171]

Occupationally exposed persons are not included in this definition for notification purposes, but see pages 62-64 regarding disclosure when there has been an occupational exposure.

b. WHO MUST (AND MAY) REPORT CONTACTS

i. MANDATORY REPORTING OF CONTACTS.

Physicians and other diagnostic providers who also are mandated HIV/AIDS case reporters have a legal duty to report the known contacts of an individual whose case of HIV infection, HIV-related illness or AIDS they initially diagnose

[170] 45 C.F.R. § 164.512(b)(1)(iv).
[171] N.Y. Pub. Health Law § 2780(10); 10 N.Y.C.R.R. § 63.1(m).

and report. This duty applies only to those who are mandated to report the case, and requires only the reporting of those contacts known to or provided to the reporter at the time the mandated case report is made (see page 52, on who must make case reports, and when).

ii. PHYSICIANS' DISCRETIONARY REPORTING OF CONTACTS.

Except for reporting known contacts when making mandated HIV/AIDS case reports, physicians have no obligation to locate or identify any contact.[172] But physicians may, without obtaining an HIV-specific release form, report the names of contacts (as well as information about the HIV-infected patient involved) to public health authorities for the purpose of initiating notification efforts, if:

- the physician believes that notification is **medically appropriate** and there is a significant risk of infection to the contact;[173] and
- the physician or his agent has given the protected individual the **counseling** and **information** about notification described below and the required **domestic violence screening** has been applied (see page 58).[174]

iii. OTHERS.

No one else has a duty to report any contact, or may (except as page 59 notes).

c. WHAT MUST BE REPORTED

When making a mandated HIV/AIDS case report, the physician or other diagnostic provider must report the following contact information:

- information identifying the protected individual, including his/her name and address, contact and locating information, and other information including demographic information;
- the names and addresses, if available, of contacts known to the reporter or provided to the reporter by the protected individual; this includes contacts that the reporter
  - » learns about while providing medical care to the individual,
  - » learns from the individual in post-test counseling, and
  - » already knows about even through other sources;
- information concerning the required domestic violence screening for each reported contact (see page 58);
- whether the reporter conducted post-test counseling;
- whether the notification has been done or, if not, whether the reporter intends to notify the contact(s) personally or make a referral to public health authorities for notification; and
- if the reporter conducted the notification, the results, including the date each contact was notified.[175]

[172] N.Y. Pub. Health Law §§ 2782(4)(c); 2783(3); 10 N.Y.C.R.R. 63.8(i).
[173] N.Y. Pub. Health Law § 2782(4)(a)(2).
[174] N.Y. Pub. Health Law §§ 2782(4)(a); 2137; 10 N.Y.C.R.R.§§ 63.4(b); 63.8(l).
[175] N.Y. Pub. Health Law § 2130(3); 10 N.Y.C.R.R. §§ 63.4; 63.8(a)(1).

d. WHO RECEIVES THE REPORTS

Information about known contacts must be included in mandated HIV/AIDS case reports to the State Department of Health, which must promptly forward it to designated local public health officials in the county/city where the protected person lives.[176] Physicians who exercise their discretion to report contacts at other times (see page 56) may call the partner notification assistance programs listed on page 57.

e. TIME LIMIT ON MAINTAINING CONTACT INFORMATION

Local public health officials must forward information about their contact notification activities to the State Department of Health. Neither state nor local public health officials may maintain contact names (obtained from the reporter or from their own contact notification activities) for more than three years following completion of notification activities.[177]

3. CONTACT NOTIFICATION

a. WHEN NOTIFICATION MUST AND MAY BE DONE

i. BY PUBLIC HEALTH AUTHORITIES

Public health officials have the primary responsibility for conducting or verifying that contact notification has been done. They must take "reasonable measures" to follow up contact reports and undertake notification efforts when they determine that it is **merited in order to protect the public health.**[178] In deciding when notification is "merited," they must give priority to those cases where:

- contacts were reported: contacts are identified in HIV/AIDS case reports, including spouses and individuals whom the HIV positive person wants to have notified, unless the reporter certifies that they have already been notified; and
- new diagnosis: the report concerns a person newly diagnosed with HIV infection.[179]

Public health staff also must respond to all requests from individuals with HIV/AIDS and their health care providers for assistance in notifying contacts.[180]

ii. BY PHYSICIANS

Physicians are **never obligated** to — and cannot be held liable if they do not — notify contacts personally.[181] (They must, however, report known contacts to the public health authorities, when making mandated case reports. See above.)

At any time, a physician may directly notify the patient's contact(s), or may ask public health officials to do so, if the patient signs an HIV-specific release form. If

[176] N.Y. Pub. Health Law § 2130; 10 N.Y.C.R.R. §§ 63.4(b); 63.8(a)(2).
[177] 10 N.Y.C.R.R. § 63.8(j).
[178] N.Y. Pub. Health Law §§ 2133(1) and 2782(4)(a)(6).
[179] 10 N.Y.C.R.R. § 63.8(b).
[180] 10 N.Y.C.R.R. § 63.8(e).
[181] N.Y. Pub. Health Law § 2783(3)(a); 10 N.Y.C.R.R. §63.8(i).

the patient does not sign an HIV-specific release form, then in circumstances other than mandated HIV/AIDS case reporting, a physician may initiate notification — by disclosing the patient's and contacts' names to public health officials and asking them to do the notification, or by notifying contacts directly — but **only** if the physician:

- concludes that notification is **medically appropriate** and that the contact may face a **significant risk of infection**;
- counsels (or tries to counsel) the HIV-positive individual about the need to notify the contact;
- conducts the required domestic violence screening with respect to each contact, in accordance with the Department of Health protocol (see below); and
- informs the patient of:
  - » the physician's intent to notify the contact(s),
  - » the physician's responsibility to report the case and contact(s) to the public health authorities,
  - » the patient's option to express a preference for the physician or public health staff to do the notification (the physician must honor a patient's preference for public health authorities to do the notification but, even when a patient prefers that the physician do it, can decline and have it done by public health staff instead), and
  - » the fact that the protected individual's name may not be disclosed during notification.[182]

Physicians and patients may prefer to have public health staff notify contacts since they always perform notifications in person and are specially trained. These contact notification programs are:

- New York State Department of Health "Partner Services": 800-541-AIDS, and
- New York City Contact Notification Assistance Program (C-NAP): 212-693-1419 or 311.

iii. BLOOD, ORGAN AND TISSUE DONATIONS

Blood banks, organ procurement organizations, and tissue banks that ascertain that their donors are HIV positive may disclose that information to the donor's physician so that known contacts can be notified.[183]

b. COMMUNICATING WITH THE PROTECTED INDIVIDUAL

When public health officials conduct notification activities, they must confirm that the protected individual has received post-test counseling, which must include counseling about HIV-positive individuals' need to notify their contacts and their notification options (see page 15).

[182] N.Y. Pub. Health Law § 2782(4)(a); 10 N.Y.C.R.R. § 63.8(a)(l).
[183] 10 N.Y.C.R.R. § 63.8(k).

Public health staff may communicate with the protected person, when needed, to seek cooperation in notification efforts, verify information about the identity or location of known contacts, and conduct or confirm the domestic violence screening and make necessary referrals. But any communications with the individual must be in a confidential, private and safe manner.

If the individual cannot be located for post-test counseling or declines to be assessed for domestic violence risk, the public health official must determine, in consultation with the reporting physician, whether to proceed with contact notification.[184]

c. DOMESTIC VIOLENCE SCREENING

Neither public health authorities nor physicians may notify any contact without first assessing the risk of domestic violence to the protected individual and contact in accordance with a protocol developed by the Department of Health, and addressing any such risk.[185]

Therefore, local public health authorities may not conduct notification without first confirming (or obtaining) and considering information from the domestic violence screening protocol. (The Department of Health has published various materials regarding the domestic violence screening protocol, which can be obtained through the AIDS Institute's website, www.health.ny.gov/diseases/aids.) In so doing, they may consult with the provider who made the case or contact report and consider information that the protected individual gave, and if necessary, they may communicate directly with the protected individual in a confidential, safe manner.

Notification may not occur unless the official is satisfied, in his/her professional judgment, that "reasonable arrangements, efforts or referrals to address the safety of affected persons have been made."[186] Department of Health guidelines advise that notification should be deferred if the domestic violence screening indicates a risk of severe negative effect on the health and safety of the protected individual, his/her children or person(s) close to them, or a contact.

d. NOTIFYING THE CONTACT

Public health officials must make a "good faith effort" to notify known contacts where merited to protect the public health and, where the contacts live outside of the protected individual's jurisdiction, to notify public health officials in the contact's jurisdiction.[187] In doing this, they (as well as physicians who conduct notification activities) must adhere to the following rules.

i. COUNSELING THE CONTACT

The person notifying the contact must provide counseling or make an appropriate referral for counseling and testing. This counseling must be in person unless reasonable circumstances prevent it (for instance, the contact prefers it to occur by phone). The counseling must address:

[184] 10 N.Y.C.R.R. § 63.8(f).
[185] N.Y. Pub. Health Law §§ 2133, 2137; 10 N.Y.C.R.R. § 63.8(c).
[186] 10 N.Y.C.R.R. § 63.8(c).
[187] 10 N.Y.C.R.R. §63.8(a)(3).

- coping emotionally with potential exposure to HIV;
- domestic violence issues;
- the nature of HIV infection and HIV-related illness, including, where appropriate, the risk of prenatal and perinatal transmission;
- the availability of anonymous and confidential testing;
- preventing exposure or transmission of HIV infection;
- discrimination that might occur from HIV-related disclosures; and
- legal protections against such disclosures.[188]

ii. CONFIDENTIALITY

The person notifying the contact **may not disclose** to the contact:

- the **identity of the protected individual** (even if the contact is a spouse); or
- the **identity of any other contact.**[189]

This protection applies even if the protected person is deceased.[190] Of course, not revealing the protected individual's name does not always guarantee confidentiality. A contact who has been monogamous and has not shared drug injection equipment may still be able to ascertain the infected person's identity. This is one reason the risk of domestic violence must be assessed and addressed before notification may proceed.

iii. DEALING WITH "VULNERABLE" POPULATIONS, INCLUDING ADOLESCENTS

When public health officials conduct notification involving "vulnerable" populations (e.g., adolescents and individuals in residential and institutional settings), they must follow Department of Health guidelines (available on the Department of Health AIDS Institute website at www.health.ny.gov/diseases/aids).[191]

4. HOW TO "WARN" CONTACTS IF YOU ARE NOT A PHYSICIAN OR PUBLIC HEALTH OFFICIAL

Providers and individuals other than physicians and diagnostic providers who are mandated HIV/AIDS case reporters have **no legal duty to notify (or ask public health authorities to notify) any contact,** including spouses. Nevertheless, they may believe they have a professional, therapeutic or ethical obligation to warn those at risk of infection through unsafe sex or sharing needles with an HIV-positive person. They may only do so as follows:

a. EDUCATE THE CLIENT

Educate the client about special confidential programs that help with partner services, including making anonymous and on-line notifications. These are New York State Department of Health Partner Services at 800-541-AIDS and, in New York City, the Contact Notification Assistance Program (CNAP) at (212) 693-1419 or 311 (see page 57).

[188] N.Y. Pub. Health Law §§ 2133(2), (4); 10 N.Y.C.R.R. § 63.8(g).
[189] N.Y. Pub. Health Law § 2133(3); 10 N.Y.C.R.R. § 63.8(a).
[190] 10 N.Y.C.R.R. §63.8(h).
[191] 10 N.Y.C.R.R. § 63.8(d).

b. WITH AN HIV-SPECIFIC RELEASE FORM

Obtain an HIV-specific release form from the protected individual (see page 36) authorizing the provider to either tell the contact or help the client tell the contact, or call Partner Services or CNAP;

c. IN SOME CASES, THROUGH A PHYSICIAN

Providers with physicians on staff may be authorized (under the internal communications rule, explained at pages 44-45) to give those physicians the relevant information and ask them to initiate any needed notification;

d. ANONYMOUS CALL TO DEPARTMENT OF HEALTH

The provider and client could call Partner Services or CNAP together, and the client can choose to either not disclose his/her status at all or self-disclose during the call. The provider should document the client's oral consent for this call; or

e. COURT ORDER

Seek a court order under Article 27-F that will authorize the disclosures needed to ensure the contact is notified, on the ground that the court-ordered disclosure is necessary to prevent "a clear and imminent danger to someone whose life or health may unknowingly be at significant risk as a result of contact" with the individual (see pages 70-71).

G. ACCESS TO NEWBORN HIV TESTING INFORMATION

1. THE RULE

Newborn Testing

Results of a newborn's HIV test must be disclosed to the:

- mother (unless she lacks capacity to consent to the newborn's health care),
- newborn's physician, and
- State Department of Health.

New York's newborn HIV testing requirement was discussed in Part 1, page 18. This section discusses who has access to the newborn's test results. Because a newborn HIV test is in reality a test of the mother (a positive test reveals that the mother has HIV, but not necessarily that the newborn is infected), the confidentiality law protects the information with respect to both the newborn and mother.[192] The following are required to receive newborn test results, whether or not the mother signs an HIV-specific release.

[192] 10 N.Y.C.R.R. §§ 69-1.3(l)(3), 69-1.5(g)(3).

a. MOTHER

If positive, a newborn's HIV test results must be disclosed to the mother, unless she lacks capacity to consent to health care for the newborn. In such cases, the results must be given to the individual with authority to consent to such care (which, depending on the circumstances, might be the father or other person authorized by law).[193] This means that the father does not have the legal right to obtain the newborn's test result unless the mother lacks capacity to consent, and the father is the individual with authority to consent to health care for the newborn. If there is no record that the mother had an HIV test during the pregnancy, the results must be given "as soon as practicable," but no later than twelve hours after birth.[194]

b. PHYSICIAN

The newborn's HIV test results (positive or negative) must be given to the newborn's physician/primary health care provider. As the child ages, the records may be disclosed to other health care providers on the same basis as any other individual's HIV-related information: when necessary for care of treatment of the child (see pages 46-47). The newborn's test results also must be given to the mother's physician.[195]

c. SPECIALIZED CARE CENTERS

When the newborn's physician requests, the newborn's HIV test results must be disclosed to an HIV specialized care center — a publicly funded facility to which HIV-positive newborns and their mothers must be referred.[196]

d. STATE DEPARTMENT OF HEALTH

The delivering hospital must provide the Department of Health with the names of newborns who test positive, as well as other data required by the Department of Health.[197] These disclosures are all permitted under HIPAA, as well, because HIPAA allows disclosures to parents and guardians of minors and to health care providers for purposes of treatment, and disclosures required under state public health reporting laws.

2. DOCUMENTING THE TEST RESULTS

Newborn HIV test results, like all other HIV test results (see page 76), must be documented in the newborn's medical record.[198]

[193] Department of Health memorandum, Series 97-2, 1/24/97.
[194] 10 N.Y.C.R.R. § 69-1.3(l)(2).
[195] 10 N.Y.C.R.R. § 69-1.5(g)(4).
[196] 10 N.Y.C.R.R. § 69-1.5.
[197] 10 N.Y.C.R.R. §§ 69-1.3(6); 69-1.4(2); 69-1.5(6).
[198] N.Y. Pub. Health Law § 2782(8); 10 N.Y.C.R.R. §§ 69-1.3(l)(3); 69-1.5(g)(3).

H. OCCUPATIONAL EXPOSURES

Article 27-F allows the physicians of individuals who may have experienced an on-the-job exposure to HIV in specified occupational settings to be told the HIV status of the "source" of the exposure in limited circumstances, without the source's consent.[199] In limited circumstances, Article 27-F also allows for HIV testing of the "source" (see page 20).[200]

Such disclosures are also permitted under HIPAA, which allows disclosures of protected health information to a health care provider for the purpose of treatment, and also allows disclosure of protected health information to an individual when it is necessary to prevent or lessen a serious and imminent threat to the health of the individual.[201]

1. THE RULE

Occupational Exposure

"Source" person's HIV status may be disclosed to occupationally exposed worker if:

- the exposure occurred in job setting covered by the law,
- there is risk of transmission of HIV as determined by medical experts, and
- procedural and other requirements have been met.

2. OCCUPATIONAL SETTINGS WHERE RULE APPLIES

Disclosures of the source patient's status are only allowed in cases where staff, employees, or volunteers are exposed while performing their professional duties in the following occupational settings:

- Medical or dental offices (public or private);
- Facilities regulated, authorized or supervised by specified state agencies:
  - » Department of Health (e.g., hospitals, laboratories, home health care providers);
  - » Office of Alcoholism and Substance Abuse Services (e.g., alcohol and drug treatment facilities);
  - » Office of Mental Health (e.g., halfway houses);
  - » Office for People with Developmental Disabilities[202] (e.g., community residences, group homes);
  - » Office of Children and Family Services (e.g., foster care agencies)
  - » Department of Correctional Services (state prisons); and

[199] 10 N.Y.C.R.R. §63.8(m).
[200] N.Y. Pub. Health Law § 2781(6)(e).
[201] 45 C.F.R. § 164.512(j).
[202] Note that the regulations still refer to this agency by its previous name, the Office of Mental Retardation and Developmental Disabilities.

- Settings where emergency response personnel (paid or volunteer) — Including emergency medical technicians, firefighters, law enforcement officers (police, probation, parole), or local correctional officers or medical staff — are performing an emergency response function.[203] However, if the emergency response employee is governed by federal law, federal law will govern, not Article 27-F.[204]

Disclosures of the source patient's status are not allowed for occupational exposure in facilities not on this list, such as schools, day care centers, churches, and community-based organizations.

3. WHEN DISCLOSURES CAN BE MADE

Disclosures are permitted only when all of these conditions are met:

a. ON-THE-JOB EXPOSURE

When exposure occurs during performance of the employee's job, in one of the occupational settings discussed above;

b. RISK OF HIV TRANSMISSION

The incident must present a risk of HIV transmission, as determined by medical experts in accordance with Department of Health standards. This means:

- exposure is to one of these potentially infectious body substances: blood, semen, vaginal secretions, breast milk, tissue or certain other fluids (exposure to other substances — including urine, feces, saliva, sweat, tears, nasal secretions, vomit not containing visible blood — does not present a risk); and
- there is direct contact between the potentially infectious substance and the employee's non-intact skin (e.g., open wound), mucous membranes (e.g., eyes, nose, mouth), or vascular system (examples include needle sticks, puncture wounds and direct saturation/permeation of non-intact skin; but not human bites without direct blood-to-blood or blood-to-mucous membrane contact, contact with intact skin, contacts in settings where scientifically accepted barrier techniques are not breached).[205]

c. INCIDENT REPORT

A report detailing the exposure, including witnesses, must be filed with supervisory staff;[206]

d. REQUEST BY EXPOSED WORKER

The exposed worker or his/her medical provider must request the information about the source's HIV status as soon as possible after the incident, and must need the information to decide whether to begin or continue post-exposure prophylaxis;[207] and

[203] 10 N.Y.C.R.R. § 63.8(m)(3).
[204] 10 N.Y.C.R.R. § 63.8(m).
[205] 10 N.Y.C.R.R. §§ 63.8(m)(1)-(2); 63.10(d).
[206] 10 N.Y.C.R.R. § 63.8(m)(4).
[207] 10 N.Y.C.R.R. § 63.8(m)(5).

e. DOCUMENTATION

The request must be documented in the exposed employee's medical record, although the rule does not require the employee's test result to be put in his/her personnel records.[208]

When all of the above conditions are met, and the appropriate health care provider or medical officer determines, in his/her professional judgment, that there is a risk of transmission, the provider or officer may disclose the HIV status of the source, if known, to the exposed person's physician and, without identifying the name of source patient, to the exposed person.[209]

4. CONFIDENTIALITY

The **source's name may not be provided** to the exposed employee. If the employee already knows the source's identity, s/he may not disclose the source's HIV status to anyone, except as authorized by the law. The provider or officer who released the source's HIV status to the exposed employee is also prohibiting from re-disclosing the source's HIV status, except as permitted by law.[210]

5. TESTING THE SOURCE

Providers may, in certain circumstances, test the source of an occupational exposure to determine his/her HIV status, and reveal the results of the test (but not the source's identity) to the exposed employee. For a detailed discussion of testing the source of an occupational exposure, see page 20.

6. OCCUPATIONAL EXPOSURES IN SETTINGS NOT COVERED BY THIS EXCEPTION

If an occupational exposure occurs in a setting not covered by this exception (e.g., school, church, or community based organization), the source's HIV status may be disclosed only with the source's consent, with a court order issued under Article 27-F (see pages 70-72), or as otherwise authorized by Article 27-F.

I. FOSTER CARE AND ADOPTION

Many parties involved in foster care and adoption want — and may legitimately need — HIV-related information about foster and adoptive children, as well as their foster, adoptive and birth parents. This section discusses the circumstances under which this information may and, in some cases, must be shared among the interested parties without consent.

(See also page 40, explaining who has authority to consent to HIV-related disclosures about children, including foster children, and pages 6-9, dealing with HIV testing of children in foster care.) Two publications by the New York State Office of Children and Family Services (OCFS) provide useful guidance on these issues: *Working Together: Health Services for Children in Foster Care* ("Working Together") (3/1/09) and *Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and*

[208] 10 N.Y.C.R.R. § 63.8(m)(6).
[209] 10 N.Y.C.R.R. § 63.8(m)(7).
[210] *Id.*

Disclosure, 97 ADM-15, July 24, 1997 ("OCFS 97 ADM-15"). Both are available on the OCFS website at www.ocfs.state.ny.us.

1. DISCLOSURES ABOUT FOSTER CARE AND ADOPTIVE CHILDREN'S HIV STATUS

a. DISCLOSURES TO "AUTHORIZED AGENCIES"

Health and social service providers (and others covered by the law) may disclose HIV-related information about foster care or pre- or post-adoptive children, without consent, to "an authorized agency in connection with foster care or adoption of a child."[211]
An "authorized agency" includes –

- licensed foster care and adoption agencies that are authorized by the State Office of Children and Family Services or local social services district to care for, place out or board out children;
- government social service officials who are authorized by law to place out or board out children; and
- any court.[212]

Disclosures are justifiable only when the HIV-related information is directly relevant to a particular foster care or adoption proceeding. And, though consent is not required, obtaining an HIV-specific release form where practicable is consistent with the general philosophy of Article 27-F favoring consensual disclosures.

b. DISCLOSURES BY "AUTHORIZED AGENCIES"

The authorized agencies referred to in this section are foster care and adoption agencies, and the governmental social service agencies and officials responsible for foster care and adoption matters.

i. TO FOSTER/ADOPTIVE PARENTS

"Authorized agencies" **must** disclose the "medical history" of a child in foster care or adoption proceedings — including HIV-related information — to the child's prospective and current foster/adoptive parents[213] as described below. These disclosures are permitted by Article 27-F.[214]

Upon placement into foster care, to the extent the information is available. Prospective adoptive parents of a child legally freed for adoption should be given it once they have been determined to meet the criteria for adoption, have indicated an interest in adopting a particular child, and the agency has begun the placement agreement process.

After placement, upon request. Once a child is in foster care or has been adopted, medical history (including HIV) information about the child must be disclosed "upon request" by the adoptive/foster parent.[215] Medical history information

[211] N.Y. Pub. Health Law § 2782(1)(h).
[212] N.Y. Soc. Svc. Law § 371(10).
[213] N.Y. Soc. Svc. Law § 373-a. The regulations refer to the medical history as a "comprehensive health history." 18 N.Y.C.R.R. §§ 357.3(b); 421.2(d).
[214] N.Y. Pub. Health Law § 2781(1)(h).
[215] N.Y. Soc. Svc. Law § 373-a.

about the child's birth parents also must be given to foster/adoptive parents (see page 68).

These disclosures are required whether or not the child has capacity to consent, or signs an HIV-specific release form. This means, for example, that if an adolescent in foster care chooses to have a confidential (as opposed to anonymous) HIV test, the results will be given to the foster parents even if the adolescent does not consent to the disclosure. In contrast, the birth parents of a foster child with capacity to consent generally may not be told their child's test results or any other HIV-related information without the child's consent (see pages 49-51).

ii. TO LAW GUARDIANS

"Authorized agencies" **must** disclose HIV-related information "relating to" a foster/adoptive child to the child's law guardian (the lawyer who represents the child's interests in foster care, adoption, or child abuse and neglect proceedings) without consent (even if the child has capacity to consent), **but only** for the purpose of representing the child in that proceeding or certain other family law matters.[216]

Since this rule permits disclosure of any HIV-related information "relating to the minor," a law guardian also may be given HIV-related information about a foster/adoptive child's siblings, assuming it is necessary for representing the minor.

Re-disclosure by the law guardian. If the child has capacity to consent, the law guardian may not re-disclose the information (e.g., to the court, birth parent or anyone else) without an HIV-specific release form signed by the child or as authorized by a court order issued in accordance with Article 27-F (see pages 70-72). If the child lacks capacity to consent, the law guardian may re-disclose the information, but only for the purpose of representing the child.[217] The law guardian may sometimes re-disclose the information to the birth parent(s) of a child who lacks capacity to consent, but only when necessary and relevant to the legal proceeding.

iii. TO OTHER FOSTER CARE/ADOPTION AGENCIES

"Authorized agencies" **must** disclose the "medical history" – including HIV-related information – to other authorized foster care/adoption agencies when the child is transferred there, regardless of the child's capacity to consent.[218]

iv. TO THE FOSTER CHILD

"Authorized agencies" **must** disclose the "medical history" – including HIV-related information – to the foster child who is discharged to his own care or is adopted and requests the information, regardless of the child's capacity to consent.[219]

[216] N.Y. Pub. Health Law § 2782(1)(p); Working Together, p. 7-7; OCFS 97 ADM-15, p. 31.
[217] N.Y. Pub. Health Law § 2782(1)(p).
[218] 18 N.Y.C.R.R. § 357.3(b)(1); Working Together, p. 7-7; OCFS 97 ADM-15, p. 31.
[219] 18 N.Y.C.R.R. § 357.3(b)(6); Working Together, p. 7-7; OCFS 97 ADM-15, p. 31.

v. TO THE BIRTH PARENTS

"Authorized agencies" **must** disclose HIV-related information to the birth parents without consent *if* the child lacks capacity to consent, but only with the child's consent, if the child has capacity.[220]

vi. TO SERVICE PROVIDERS

"Authorized agencies" **must** disclose HIV-related information to community service providers (e.g., psychologist, home aide, day care or school staff) when necessary to obtain essential health or social services for the child, *but only* if the local social services commissioner or designee has signed an HIV-specific release form authorizing the disclosure (see page 36 regarding who has authority to give consent).

Note that disclosures to day care and school staff may be made only when necessary for administration of medication or another medical need. [221]

vii. TO THE COURT; IN COURT

Since courts are "authorized agencies," Article 27-F allows foster/adoptive agencies to give them HIV-related information, without consent, "in connection with foster care or adoption of [the] child."[222]

Foster/adoptive agencies may also make in-court disclosures about such children, if authorized by consent from the appropriate person. They must disclose HIV-related information in a court hearing related to the foster child if ordered by a judge in accordance with the court order provisions of Article 27-F.[223]

c. DISCLOSURES BY FOSTER/ADOPTIVE PARENTS

Foster parents may disclose HIV-related information about their own foster child without consent, but only for the "purpose of providing care, treatment or supervision" of the child.[224] In other instances, the foster parents must obtain consent from the appropriate person (e.g., birth parent or social service officials, depending on the case).

Prospective adoptive parents with whom a child has been placed and adoptive parents may freely disclose HIV-related information about their child.[225]

d. DISCLOSURES BY BIRTH PARENTS

Birth parents who retain the legal authority to make health care decisions for their child in foster care may freely disclose HIV-related information about their own child who lacks capacity to consent (§ 2782(1)(a)). Birth parents who learn from their own child his/her HIV status may legally re-disclose it.

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[220] Working Together, p. 7-7; OCFS 97 ADM-15, p. 31. See also 18 N.Y.C.R.R. § 357.3(b)(5), requiring the disclosure of HIV-related information to parent/guardian when child is released to their care, but only with consent of the child if the child has capacity to consent.

[221] Working Together, p. 7-7; OCFS 97 ADM-15, p. 32.

[222] N.Y. Pub. Health Law § 2782(1)(h).

[223] Working Together, p. 7-7; OCFS 97 ADM-15, pp. 31-32.

[224] N.Y. Pub. Health Law §2782(3)(c), (e)

[225] N.Y. Pub. Health Law § 2782(3)(d); Working Together, p. 7-7; OCFS 97 ADM-15, p. 32.

e. DISCLOSURES BY THE FAMILY COURT

The court may disclose HIV-related information about a child in connection with foster care or adoption proceedings[226] and may issue an order authorizing others to disclose such information, but only in accordance with the special court order requirements explained at pages 70-72.

2. DISCLOSURES ABOUT FOSTER AND PRE-ADOPTIVE PARENTS' HIV STATUS

a. DISCLOSURES BY AUTHORIZED AGENCIES

"Authorized agencies" must maintain the confidentiality of HIV-related information about foster and pre-adoptive parents.[227] They may not re-disclose it to their foster/adoptive child's birth parent or others without an HIV-specific release form or an authorizing court order.

Nor should they generally re-disclose it to the court without the foster/adoptive parent's consent. Though the law allows HIV-related disclosures to courts "in connection with foster care or adoption of a child",[228] this type of a non-consensual disclosure would be justifiable only if directly relevant to the case. The mere fact that a foster/adoptive parent has HIV/AIDS does not supply that justification.

3. DISCLOSURES ABOUT BIRTH PARENTS' HIV STATUS

a. TO FOSTER/ADOPTIVE PARENTS

The Social Services Law requires "authorized agencies" to give prospective and current foster/adoptive parents the "medical histories" (including available HIV-related information) of the birth parents of a child legally freed for adoption or placed in foster care, just as it does with the child's medical history, and in the same time frames (see page 65).[229] However, the identity of the birth parent may not be disclosed to the foster/adoptive parents, unless either:

- the birth parent signs an HIV-specific release form; or
- the court issues an order authorizing disclosure of the parent's identity along with the HIV-related information, in accordance with Article 27-F's court order requirements (explained at pages 70-72).[230]

b. TO LAW GUARDIANS

"Authorized agencies" **must** disclose HIV-related information "relating to" a foster/adoptive child — which sometimes might include HIV-related information about the child's birth parents, if directly relevant to the issues in the case — to the child's law guardian, but only if necessary to represent the child (see page 66).[231] Law guardians

[226] N.Y. Pub. Health Law § 2782(1)(h).
[227] N.Y. Pub. Health Law § 2782(3).
[228] N.Y. Pub. Health Law § 2782(1)(h).
[229] N.Y. Soc. Svc. Law § 373-a; 10 N.Y.C.R.R. § 357.3(b).
[230] N.Y. Soc. Svc. Law § 373-a.
[231] N.Y. Pub. Health Law §2782(1)(p).

must comply with Article 27-F in re-disclosing any information about the birth parents' HIV status.

c. TO FOSTER/ADOPTIVE CHILD

"Authorized agencies" **must** disclose the birth parent's "medical history" – including HIV-related information – to the foster child who is discharged to his own care or is adopted and requests the information. However, information identifying the birth parents must be eliminated.[232]

J. DISCLOSURES TO THIRD-PARTY PAYERS AND INSURERS

As noted previously, Article 27-F has limited application to insurers (see pages 22 and 34). But health and social service providers and others who are covered by Article 27-F must comply with the law in disclosing HIV-related information about individuals to insurance companies and other third-party payers. This section explains how providers may disclose HIV-related information to insurers. In short, they generally do not need the HIV-specific release form required in other contexts.

Although HIPAA permits providers to disclosure health information for purposes of payment and health care operations without a release, Article 27-F is "more stringent" regarding release of HIV-related information to insurers and other third-party payers (as described below), and therefore providers must comply with Article 27-F. However, insurers and other third party payers, while subject to HIPAA as "health plans," are generally not subject to Article 27-F's confidentiality requirements (see page 34).

1. HEALTH CARE REIMBURSEMENT CLAIMS

When health care providers contact insurers to obtain reimbursement for health care services, they generally are not required to get consent on an HIV-specific release form. Instead, they may use an "otherwise appropriate authorization," which means an authorization for the release of medical records.[233] This provision, however, has several important limitations:

- **For health care reimbursement only.** It only applies when the disclosure to the insurance company is for the purpose of getting reimbursed for health care.
- **General release still needed.** The provider must obtain "appropriate authorization" as required by other applicable laws or regulations. General release forms authorizing the release of medical information will satisfy legal requirements for most health care providers. However, most alcohol and drug treatment programs must use the special release forms required by federal law.[234]
- **Disclose only "to the extent necessary"** to obtain reimbursement for the health services. For example, if a provider seeks reimbursement for HIV-specific health care, the provider may need to release HIV-specific information so the third-party payer can verify the nature of the services provided. But if the provider seeks reimbursement for treating a broken ankle, then there may be no need to disclose HIV-specific information.[235]

[232] N.Y. Soc. Svc. Law § 373-a; 18 N.Y.C.R.R. § 357.3(b)(6).
[233] N.Y. Pub. Health Law §§ 2782(1)(i); 2784.
[234] *See* 42 U.S.C §§ 290dd-2; 42 C.F.R. Pt. 2, § 2.31.
[235] N.Y. Pub. Health Law § 2782(1)(i).

2. DISCLOSURES TO INSURERS FOR OTHER PURPOSES

Article 27-F states that health and social service providers that disclose information to insurance institutions (including HMOs and MCOs) for purposes other than reimbursement for health care services — for example, in connection with a disability, life or health insurance application, or for quality assurance or utilization review — do not need to use the special HIV-specific release form. However, the law then describes the type of written authorization that these insurers must use, and it is virtually identical to the HIV-specific release form.[236] Providers also must give the insurer the notice prohibiting re-disclosure (see page 41).[237]

K. COURT-ORDERED DISCLOSURES

Article 27-F establishes four permissible grounds for issuing a special court order authorizing the disclosure of confidential HIV-related information about an individual.[238] Although HIPAA has less restrictive rules governing subpoenas and court orders, Article 27-F is "more stringent" and therefore providers must follow it when dealing with subpoenas and court orders.

1. THE RULE

Court Orders

Courts may order disclosure of HIV-related information if special procedures are followed and the court finds:

- compelling need for disclosure for adjudication of a criminal or civil case, or
- clear and imminent danger to life or health of person unknowingly at significant risk, or
- clear and imminent danger to public health, or
- applicant is lawfully entitled to the information, and disclosure is consistent with Article 27-F.

a. COMPELLING NEED FOR ADJUDICATION OF A CRIMINAL OR CIVIL CASE

A court might find a "compelling need" for a disclosure in a civil case[239] where, for example, Jane sued John for infecting her with HIV by having unprotected sex without disclosing his HIV status. Some courts have found a "compelling need" to disclose John's HIV status because Jane's claim is dependent on his being HIV positive. Such a "compelling need" might be found in a criminal case if, for example, Joe were being prosecuted for the crime of reckless endangerment for having unprotected sex without divulging he had HIV. At least one court has ordered the defendant's HIV status disclosed, as necessary to prove such a case.

b. CLEAR AND IMMINENT DANGER TO AN INDIVIDUAL'S LIFE OR HEALTH

A court may order a disclosure where it finds "a clear and imminent danger to an individual whose life or health may unknowingly be at significant risk as a result of contact" with the individual about whom the HIV-related information pertains.[240] This could justify an

[236] *See* N.Y. Pub. Health Law § 2782(1)(j).
[237] N.Y. Pub. Health Law § 2782(5).
[238] N.Y. Pub. Health Law § 2785.
[239] N.Y. Pub. Health Law § 2785(2)(a).
[240] N.Y. Pub. Health Law § 2785(2)(b).

order permitting a wife to be told that her husband is infected, where she is unaware of his diagnosis, and identifying him is the only effective way to warn her of her risk.

c. CLEAR AND IMMINENT DANGER TO THE PUBLIC HEALTH

Only public health authorities may seek an authorizing order on this ground.[241] At the time this manual was published, the authors knew of only one time when such an order was granted by a New York court: in a highly publicized case about a man with HIV who, without revealing his status, had unprotected sex with many teenage girls. The court authorized his name and picture to be published to help criminal justice authorities locate him, and to alert his sexual contacts about his HIV status.

d. APPLICANT LAWFULLY ENTITLED TO THE DISCLOSURE

One example of when an applicant is lawfully entitled to the disclosure is where someone is seeking HIV-related information from a party who refuses to give it even though the disclosure is legal under Article 27-F.[242]

e. ADDITIONAL FINDING REQUIRED BY COURT

In assessing whether there is a "compelling need" or a "clear and imminent danger" under the first three grounds for issuing orders authorizing disclosures, the court must:

- make written findings of fact, including scientific or medical findings, and must cite specific evidence in the record to support each finding; and
- weigh the need for the disclosure against the harm it would cause to the individual's privacy, as well as to the public's interest in encouraging testing and preventing discrimination.[243]

2. COURTS ONLY; SUBPOENAS NOT SUFFICIENT

Only a court of competent jurisdiction may issue an order authorizing a disclosure of confidential HIV-related information,[244] and only an order issued in compliance with Article 27-F's special requirements can validly permit or compel disclosure. Thus, while a federal or state court may order disclosure, administrative bodies (such as arbitrators in union grievance proceedings, or hearing officers in welfare or unemployment insurance agencies) may not.

A subpoena, by itself, may not authorize or compel the disclosure of any confidential HIV-related information (even if the subpoena is issued by a court or signed by a judge). While a subpoena is an "order," in that it commands someone to do something, it does not constitute the special kind of court order required under Article 27-F. (See page 79), discussing how to respond to a subpoena seeking HIV-related information.)

3. PROCEDURES FOR SEEKING A COURT ORDER AUTHORIZING DISCLOSURE

The following special procedures must be followed whenever an order is sought under § 2785, so that the persons affected have an opportunity to participate in the proceeding and to ensure the proceeding's confidentiality:

[241] N.Y. Pub. Health Law § 2785(2)(c).
[242] N.Y. Pub. Health Law § 2785(2)(d).
[243] N.Y. Pub. Health Law § 2785(5).
[244] N.Y. Pub. Health Law § 2785(1).

a. NOTICE

The person to whom the confidential HIV-related information pertains, as well as any person or agency that is holding the records or information being sought, must be given "adequate notice" of an application for an order, and be notified in a manner that will not reveal to others the identity of the person to whom the confidential information pertains.

b. OPPORTUNITY TO RESPOND

Both the person to whom the confidential information pertains and the person or agency from whom the information is sought must have an opportunity to file a written response to the application, or appear in person, for the limited purpose of giving evidence on whether the statutory criteria for issuing an order have been met.

The only time a court may issue an order without providing the required notice and opportunity to be heard is when a public health official applies for a disclosure order under the third ground described above, and shows that the circumstances require an immediate order.

c. CONFIDENTIALITY OF PROCEEDINGS

When a court receives an application for any order authorizing disclosure, it must take these steps to ensure that the proceedings are confidential:

- order all papers that are part of the application or decision to be sealed and not made available to anyone except those directly involved in the application (or appeal, if there is one);
- conduct the proceeding to determine whether to grant the application "in camera" (i.e., not open to the public); and
- take any necessary steps to prevent the name of the individual to whom the HIV-related information pertains from being revealed in any of the application or decision papers).[245]

4. THE COURT ORDER

Finally, if the court decides that an order authorizing the disclosure should be issued, it must:

- limit disclosure to the information necessary to fulfill the purpose of the order;
- limit disclosure to the persons whose need for the information is the basis for the order, and specifically prohibit re-disclosure by those persons;
- conform to Article 27-F's provisions and policy to the extent possible; and
- include any other measure the court deems necessary in order to limit any disclosures not authorized by the order.[246]

[245] N.Y. Pub. Health Law § 2785 (1)-(4).
[246] N.Y. Pub. Health Law § 2785(6).

L. PROGRAM MONITORING, EVALUATION OR REVIEW

Under both Article 27-F and HIPAA, certain private and government oversight authorities may obtain HIV-related and other health-related information from the agencies they oversee, without an HIV-specific release form from the individuals whose HIV-related information is being disclosed. Because Article 27-F is "more stringent" in this regard than HIPAA, providers must follow Article 27-F's restrictions.

1. THE RULE

Program Monitoring, Evaluation or Review

Certain oversight authorities may obtain HIV-related information from entities they oversee, without an HIV-specific release form from the client, if they:

- use it for program monitoring, evaluation and review only; and
- do not re-disclose HIV-related information to anyone, except
  - back to the program being monitored
  - if a government agency oversees or administers the program, to the government oversight agency.

2. WHAT IS AN OVERSIGHT AUTHORITY?

Oversight authorities include a "health facility staff committee or an accreditation or oversight review organization" that is "authorized to access medical records" of a health or social service provider.[247]

3. GOVERNMENT OVERSIGHT AUTHORITIES

When a federal, state or local government agency supervises or monitors a provider of health or social services or administers the program under which those services are provided, the service provider may disclose HIV-related information about the individual recipients of those services:

- to authorized employees of the federal, state or local government agency that supervises or monitors the provider or administers that program of services,
- when it is "reasonably necessary" for that governmental agency to have the HIV-related information in order to supervise, monitor or administer the program in question.[248]

This rule also works in reverse: the governmental agency may also disclose HIV-related information about recipients of the program's services to authorized employees of the provider when it is "reasonably necessary" for the oversight function.[249] The individual recipients of the services do not need to consent.

[247] N.Y. Pub. Health Law § 2782(1)(f).
[248] N.Y. Pub. Health Law §§ 2782(1)(f), § 2782(6).
[249] N.Y. Pub. Health Law §§ 2782(1)(f), 2782(6), 2786.

The Article 27-F regulations issued by the various state agencies with this type of oversight authority establish specific rules defining

- when communications between providers and government agencies are "reasonably necessary"; and
- which employees of the provider and governmental agency may be authorized to have access to HIV-related information for these purposes.

M. DISCLOSURES FOR MEDICAL EDUCATION, RESEARCH, THERAPY OR TRANSPLANTATION

No consent (in an HIV-specific release form) is required for disclosures of HIV-related information to health care providers or facilities

- in connection with the procurement, processing, distribution or use of human bodies or body parts (including organs, tissues, eyes, bones, arteries or fluids);
- for use in medical education, research, or therapy; or
- for transplants.[250]

N. CRIMINAL JUSTICE-RELATED DISCLOSURES

1. TO CRIMINAL JUSTICE STAFF

Authorized employees or agents of the State Division of Parole, Department of Correctional Services, Division of Probation and Correctional Alternatives and Commission of Correction are permitted to have access to HIV-related information about individuals under their agencies' jurisdiction, without consent from those individuals, in accordance with the specific agency's Article 27-F regulations. Such information may be shared only if the employee is **on the agency's need-to-know list** and has a **reasonable need** for that information to carry out his/her duties.[251]

Article 27-F also authorizes the medical directors of local correctional facilities (jails) to have access to confidential HIV-related information about inmates to the extent the medical director is authorized to obtain access to inmates' records in order to carry out his powers, functions and duties.[252] Jails' policies regarding access to HIV-related information may differ from locality to locality.

2. PEOPLE CONVICTED OF OR INDICTED FOR SEX OFFENSES

As discussed on page 21, a court may order someone who has been convicted of a sex offense or indicted for certain sex offenses to undergo an HIV test at the victim's request. The results must be communicated to the victim and the tested person, unless the tested person does not want to learn them. The victim may re-disclose the results to his/her immediate family, guardian, physicians, attorneys, medical or mental health providers, and past and future contacts to

[250] N.Y. Pub. Health Law § 2782(1)(e).
[251] N.Y. Pub. Health Law §§ 2782(1)(m), 2782(1)(l)), 2782(1)(o).
[252] N.Y. Pub. Health Law §§ 2782(1)(n), 2786(2)(a).

whom there was or is a reasonable risk of HIV transmission. The results may not be given to the court.[253] HIPAA also permits this disclosure.[254]

O. CHILD ABUSE/NEGLECT AND ELDER ABUSE/NEGLECT

Neither Article 27-F nor HIPAA prevents people and agencies from carrying out their duties and authority to report, investigate, or re-disclose child protective or adult protective information as required or permitted by the laws addressing child abuse and neglect and elder abuse and neglect.[255] If a person's HIV status is relevant to a report of suspected child or elder abuse, for example, then it may be disclosed without the individual's consent. It should not be assumed, however, that the HIV status of the individuals involved — either those responsible for or the victims of suspected abuse or neglect — is relevant in every case. If that information has no bearing on the specific abuse or neglect at issue, no HIV-related disclosure would be warranted.

P. ADMINISTRATORS AND EXECUTORS OF ESTATES

Article 27-F permits the disclosure of confidential HIV-related information about a deceased person to the executor or administrator of an estate to fulfill his/her responsibilities as executor/administrator.[256] HIPAA also permits this disclosure.[257]

[253] N.Y. Pub. Health Law § 2785-a.
[254] 45 C.F.R. §§ 164.512(a); 164.512 (e)(1)(i).
[255] N.Y. Pub. Health Law §2782(7); 45 C.F.R. § 164.512(c).
[256] N.Y. Pub. Health Law § 2782(1)(q)
[257] 45 C.F.R § 164.502(g)(4).

IV. RECORD-KEEPING ISSUES

A. DOCUMENTING HIV-RELATED INFORMATION IN CLIENT RECORDS

Article 27-F allows covered providers to find a workable balance between their legal duty (under professional licensure requirements or regulations establishing standards of care) to maintain accurate records about individuals in their care on the one hand, and their obligation to minimize the risk that HIV-related information might be –

- put in client records even when not directly relevant to care, and
- made accessible to people who might misuse the information, on the other.

The law requires that "confidential HIV-related information **shall be recorded in the medical record of the protected individual**" but does not specify whether it must be documented in other kinds of client records.[258] The State Department of Health regulations implementing Article 27-F require health care providers regulated by the Department to develop and implement written policies and protocols to ensure the confidentiality of any records containing HIV-related information and protect such information from unauthorized access and disclosure. These regulations state that "HIV-related information shall be recorded in the medical record such that it is readily accessible to provide proper care and treatment." [259] At the same time, they require any records containing HIV-related information to be maintained so as to ensure that such information is accessible only to those authorized to have access to it and is disclosed only as authorized by Article 27-F.[260]

Within these general guidelines, providers have the discretion to set up record-keeping systems that are responsive to their own needs. They have discretion to decide where and how to record HIV information in parts of the record other than the medical record.

Choices include recording the information in a separate part of the record or integrating it throughout. The advantage of keeping HIV-related information in a separate part of the record is that it makes is less likely that the information will be inadvertently and impermissibly disclosed – both internally and externally. The disadvantage, however, is that it may be impractical and impede the continuity and coordination of care. Some providers may also choose to use euphemisms when referring to HIV status, such as "medical condition" or "health concerns." Whichever method a provider chooses should be documented in the agency's record-keeping protocols.

Each agency should also check the Article 27-F regulations applicable to it for guidance on this issue, although these decisions are generally left up to the provider.

[258] N.Y. Pub. Health Law § 2782(8).
[259] 10 N.Y.C.R.R. § 63.7.
[260] 10 N.Y.C.R.R. §§ 63.6, 63.8.

B. DOCUMENTING DISCLOSURES

1. THE GENERAL RULE

Except as described in the next section, whenever a person or agency subject to Article 27-F discloses any HIV-related information about any protected individual, "a notation of [that disclosure] shall be placed in the medical record of the protected individual."[261] The documentation should include who requested the information (if there was a request), the date of the disclosure, who the recipient was, and authorization under Article 27-F. This requirement applies to oral and written disclosures, even if the client signed an HIV-specific release.

2. EXCEPTIONS

The only circumstances in which a disclosure need not be documented in the client's record are:

- **internal communications** among employees of a health care provider or facility who have access to HIV-related information about a particular client under the agency's "need-to-know" policy and protocol (see pages 44-45);
- **program evaluations** (see page 73);
- **governmental** payors who need the information to process payments; and
- **other than first disclosure to insurers:** the first disclosure to insurers — for reimbursement or any other purposes — must be documented in that individual's medical record. However, subsequent disclosures to the same insurer need not be noted.[262]

3. A PRACTICAL APPROACH

One sensible way of complying with these documentation requirements is to keep a running list (which could be in a separate part of a client's record) of all disclosures of HIV-related information about the individual. This will make it easier to verify all disclosures, upon client request (see next section).

C. CLIENTS' RIGHTS TO BE INFORMED OF DISCLOSURES MADE ABOUT THEM

Every individual has the right to be informed, upon his/her request, of any disclosure of confidential HIV-related information made by any covered health or social service provider, or by anyone who has received such information pursuant to individual's HIV-specific release (including insurance institutions).[263] HIPAA also requires covered health care providers to provide individuals, upon request, with an accounting of certain disclosures made regarding a patient's health care.[264]

[261] N.Y. Pub. Health Law § 2782(5)(b).
[262] N.Y. Pub. Health Law § 2782(5)(b).
[263] N.Y. Pub. Health Law § 2782(5)(b).
[264] 45 C.F.R. § 164.528 (c).

D. RESPONDING TO REQUESTS FOR HIV-RELATED INFORMATION ABOUT CLIENTS

1. DEVELOP AND FOLLOW A POLICY

The regulations implementing Article 27-F generally mandate covered providers to develop written protocols for responding to requests for HIV-related information. To fulfill these mandates and prevent any unauthorized disclosures, health and social service agencies should establish a policy like the following to deal with all requests for HIV-related information (including requests for oral disclosures as well as for records):

- The agency should designate specific staff to handle all such requests and train all employees to refer any requests to the designated staff.
- When any request for client records or information is received, the designated staff members should determine if disclosing HIV-related information in response to the request is authorized because (1) the client has signed a valid HIV-specific release form authorizing that disclosure, or (2) the requesting party is authorized to obtain the information under one of the exceptions to the general rule requiring the client's consent to the disclosure. Remember that a subpoena, even one signed by a judge, does not authorize the disclosure of HIV-related information (see page 71).
- If the agency is authorized to disclose the HIV-related information, it may make the disclosure, but must also document it and, when required, send the notice prohibiting re-disclosure to the recipient within ten days, when required (see page 41), as discussed above.
- If the disclosure is not authorized, the designated agency staff should contact the client. If the client chooses to sign an HIV-specific release form, the agency may make the disclosure. If the client does not wish to sign a release and no basis exists for making an unconsented-to disclosure, the agency staff should inform whoever is seeking the disclosure that, to the extent the information is confidential under state law, it will not be disclosed without appropriate authorization (see the next section, in this regard).

2. WHAT TO DO WHEN THERE IS NO AUTHORIZATION TO RELEASE THE INFORMATION: SUBPOENAS AND GENERAL RELEASES

How should an agency respond when it receives a release or other document that authorizes or compels disclosure of some information or records about a client, but does not provide proper authorization under Article 27-F? For example, the requesting party may give the agency a —

- general release form for a client's "medical records," or other records; or
- subpoena (or even court order, but not the type required under Article 27-F)

a. THERE ARE TWO OPTIONS

i. OPTION #1

Ask the client if he or she wishes to sign an HIV-specific release form for the disclosure. If so, have the client sign a release that complies with Article 27-F;

make the disclosure; and send the recipient the notice prohibiting re-disclosure (Appendix G).

ii. OPTION #2

Send the requesting party the information or records without the HIV-related information. This means either withholding those parts of the client's record that contain HIV-related information or redacting (blotting out) HIV-related information in the records that are sent.

If an agency chooses the second option, does it then have a legal obligation to inform the requesting party that not all of the information or records sought are being disclosed? In many cases, the agency probably does not have such an obligation. But even if it believes it does, there are ways to inform recipients that some of the records have been withheld or redacted without revealing that such information is HIV-related. For example, an agency could give all recipients of any records it discloses — whether or not those records contain HIV-related information — a general notice that says:

"This agency maintains a policy of redacting/removing from all client records any information whose confidentiality is protected under state law. No such information will be disclosed in the absence of appropriate authorization that meets the requirements of state law."

b. SUBPOENAS

The only time there may be a clear legal obligation to inform a recipient that information has been withheld or redacted is when the request is made by way of a subpoena or court order compelling disclosure. (*Remember:* a subpoena does not authorize disclosure of HIV-related information; even a court order does not authorize such a disclosure unless the court order was sought and obtained in accordance with § 2785. See pages 70-72.) While the agency cannot ignore the subpoena or court order, it may respond by —

- disclosing the records called for in the subpoena or court order except to the extent they contain HIV-related information (i.e., withhold or redact such information); and
- simultaneously sending the recipient a notice, such as the following:

  "Any information whose confidentiality is protected by Article 27-F of the Public Health Law is withheld/redacted from any records maintained by this agency before such records are disclosed in response to any subpoena or to a court order. State law prohibits the disclosure of such information in the absence of appropriate authorization. Appropriate authorization means either

  - » a written release that complies with the requirements of Article 27-F of the Public Health Law, or
  - » a special court order issued in accordance with Public Health Law § 2785.

  This notice is not intended to imply that these records contain any information protected by Article 27-F."

This informs those receiving the notice about the legal requirements for obtaining

confidential information, without revealing whether there is any such information in the records being sought. While some may read it to imply that the records they seek do contain HIV-related information, the notice itself confirms nothing.

E. SAFEGUARDING CLIENT RECORDS AND INFORMATION

1. ARTICLE 27-F

a. SAFEGUARDING PAPER AND ELECTRONIC RECORDS WITHIN THE AGENCY

All entities covered by Article 27-F should have written policies about how to safeguard the confidentiality of paper and electronic records. The policies should specify –

- where HIV-related information is maintained in paper and electronic records, who has access, and that only authorized persons can see or access the files' confidential HIV-related information, including after working hours;
- that paper files not be left on desks or otherwise viewable to unauthorized persons, that computer screens containing HIV-related information not be viewable by unauthorized persons, and paper files and flash drives be returned to their proper confidential location when they are not in use;
- whether any files – paper, flash drives, e-mailed files – may ever be removed from the premises and, if so, under what conditions;
- that documents containing confidential HIV-related information should be shredded when they are no longer needed or obsolete, or specify another method of disposing of such records.

b. FAXING AND E-MAILING CONFIDENTIAL HIV-RELATED INFORMATION

Article 27-F does not prohibit electronic transmission of HIV-related information (e.g., through fax or email), but anyone who does transmit HIV-related information electronically should take reasonable steps to ensure that it goes only to the person(s) authorized to receive it. Entities covered by Article 27-F should have written policies and procedures governing electronic transmission of HIV-related information. Where possible, people should avoid directly or indirectly revealing the identity of the individual who is the subject of HIV-related information (e.g., by using first names, initials, or non-identifying terms such as "client X"). In situations where client-identifying information must be sent electronically, some suggestions are:

- confirm the fax number or email address before sending;
- check that the fax number or email address was properly entered before clicking "send";
- when faxing, find out where the fax machine is and who has access to it at the receiving end. Do not fax anything without knowing that the person authorized to receive the information will be there to collect it;
- include the Notice Prohibiting Re-disclosure (Appendix G);
- send a "trial" fax or email (without confidential information) and confirm

that it arrived at its intended recipient. Only send the real one after receiving confirmation.

2. HIPAA

HIPAA also requires covered entities to put in place appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information from any intentional or unintentional use or disclosure which would violate HIPAA, including any incidental use or disclosure made in the course of an otherwise permitted or required use or disclosure.[265] HIPAA also sets forth specific security and electronic standards which require covered entities to have security controls and measures in place to protect confidential patient information when it is electronically stored, maintained, or transmitted.[266]

[265] 45 C.F.R. § 164.530(c).

[266] *See* 45 C.F.R. Parts 142 & 162.

V. REMEDIES FOR HIV TESTING AND CONFIDENTIALITY VIOLATIONS

A. ARTICLE 27-F

Article 27-F provides several types of redress for individuals whose rights have been violated by illegal HIV testing or disclosure of HIV-related information.

1. PENALTIES IMPOSED BY THE STATE

Individuals or agencies who —

- "perform, or permit or procure the performance of an HIV-related test" in violation of § 2781 of the law (governing HIV testing; see Part 1), or
- "disclose, or compel another person to disclose, or procure the disclosure of confidential HIV-related information" in violation of § 2782 of the law (the confidentiality and disclosure rules; see Part 2) —

face the possibility of:

- a civil penalty (fine) of up to $5,000 for each occurrence, paid to the State Department of Health,[267] and
- criminal prosecution, if the person "wilfully" commits any of the acts outlined above. This is a misdemeanor, punishable by up to one year in prison, a fine of up to $10,000 (until April 1, 2014) or $2,000 (after April 1, 2014), or both imprisonment and fine. [268]An act may constitute a "wilful" violation of the Public Health Law or its regulations if it is done deliberately and voluntarily; "bad" intention is not a prerequisite.

2. REMEDIES THAT INDIVIDUALS CAN TAKE THEMSELVES

People whose rights have been violated under Article 27-F's testing or confidentiality requirements or the HIV Reporting and Partner Notification Law may file a complaint with the Department of Health and/or bring their own lawsuit.

a. ADMINISTRATIVE REMEDIES: DEPARTMENT OF HEALTH COMPLAINTS

The State Department of Health is authorized to investigate and remedy violations of Article 27-F.[269] The Special Investigation Unit (SIU) of the Health Department's AIDS Institute takes complaints of HIV law violations. People do not need lawyers to make complaints. They can call the Department's toll-free HIV Confidentiality Hotline (1-800-962-5065), or write to the New York State Department of Health, AIDS Institute, Special Investigation Unit, 90 Church Street, New York, NY 10007. Though not required to, they can use a complaint form that the SIU and Hotline will give them upon request or download it from the the Department of Health website at http://www.health.ny.gov/diseases/aids/forms/informedconsent.htm.

[267] N.Y. Pub. Health Law §§ 12 and 2783(1).
[268] N.Y. Pub. Health Law §§ 12-b and 2783(2).
[269] N.Y. Pub. Health Law §§ 12; 12-b; 2783.

The Department of Health investigates complaints, or refers them for investigation by the agency that funds or regulates the provider involved. The SIU or other government agency conducting the investigation can require providers and/or their employees to take corrective actions, like developing needed policies or conducting training, to prevent future problems.

The Department of Health can conduct hearings to decide whether a person or agency has violated Article 27-F and, if so, what penalties or corrective actions are appropriate. It also may bring a lawsuit to recover civil penalties (e.g., get an order requiring the violator to pay a fine, which, as noted above, is awarded to the Department of Health, not to the person injured by the violation). It may ask the State's Attorney General to go to court to get an injunction (an order telling the violator to do or refrain from doing something) to prevent or remedy violations of the law.[270]

b. LAWSUITS

Individuals claiming violations of Article 27-F's HIV testing or confidentiality requirements may also bring their own lawsuits seeking injunctive relief (orders requiring those found to have violated the law to take remedial action or refrain from acting illegally) and/or monetary damages to prevent or remedy harm caused to them by unlawful testing or disclosures. The amount of damages recoverable depends on the actual damages caused by the violation (e.g., emotional distress; lost wages due to job discrimination resulting from an illegal disclosure).

People can go directly to court; they do not have to file a complaint with the SIU or exhaust any other remedies before suing. Though individuals can represent themselves, having a lawyer is extremely helpful (the Legal Action Center specializes in this area; and other legal service providers are listed in Appendix H). The time limit for filing these lawsuits is generally three years from the date of the act(s) complained of (except as noted next).

i. LAWSUITS AGAINST MUNICIPALITIES

Under New York State's General Municipal Law § 50-e, there is a shortened statute of limitations (one year and 90 days) for personal injury and many other types of lawsuits against cities, as well as a requirement to file a "notice of claim" within 90 days of the action complained of. There is a strong argument (and case law) that these requirements do not apply to lawsuits brought under Article 27-F. Nevertheless, when possible, it may be prudent to comply with these requirements in order to avoid the time and expense litigating that issue in court.

ii. RULES ON LAWSUITS BASED ON LACK OF INFORMED CONSENT TO HIV TESTING

In a lawsuit challenging a physician's (or other medical professional's) failure to obtain informed consent before ordering or performing an HIV-related test, or failing to provide the necessary pre-test information, the remedy will be governed by the rules for medical malpractice lawsuits based on the lack of informed consent to medical treatment.[271] Among other things, these suits must be filed within two and a half years after the HIV test in question was done.

[270] N.Y. Pub. Health Law §§ 2783(1)-(2); 12; 12-b.

[271] N.Y. Pub. Health Law § 2783(4). Informed consent standards are in N.Y. Pub. Health Law § 2805-d.

iii. LAWSUITS FOR VIOLATIONS OF INDIVIDUALS' CONSTITUTIONAL PRIVACY RIGHTS

Some governmental agencies and their employees — such as state or local police departments, public schools, and federal agencies like the Social Security Administration or federal prisons — are not covered by Article 27-F, and may not be sued for violating the state law (see pages 33-34). But these agencies may be sued for violating individuals' federal Constitutional privacy rights, and federal agencies may be sued under the Privacy Act.[272] Constitutional claims must be filed within three years of the privacy violation alleged, and claims under the Privacy Act must be filed within two years.

B. HIPAA

HIPAA does not give individuals a federal right to sue for violations of its privacy or other provisions, but violations may be grounds for state tort actions.

Individuals may file a complaint with the covered entity they allege has violated their rights under HIPAA's Privacy Rule. HIPAA requires covered entities to have procedures and policies in place for accepting, investigating and handling the disposition of HIPAA privacy violations. Each covered entity is responsible for establishing its own procedure for processing patient complaints.

Individuals may also file a complaint charging health care providers covered by HIPAA with violating HIPPA's Privacy Rule with the Office of Civil Rights ("OCR") of the U.S. Department of Health and Human Services (HHS).[273] HHS is the federal agency responsible for enforcing HIPAA. HHS may investigate complaints of HIPAA privacy violations by reviewing the covered entity's policies, procedures, and practices, and the circumstances regarding the alleged act or omission. HHS can impose fines or other sanctions on the covered entity for each violation.[274] Information about filing a complaint with OCR is available on its website http://www.hhs.gov/ocr/privacy/. Complaints must be filed within 180 days of discovery of the act or omission.[275]

HHS may also conduct compliance reviews to determine whether covered entities are complying with the regulations.[276] Covered entities must maintain and provide records and compliance reports, cooperate with investigations and compliance reviews, and permit access to necessary information.[277]

C. LIMITS ON PHYSICIANS' AND PUBLIC HEALTH OFFICIALS' LIABILITY

1. PHYSICIANS' IMMUNITY FOR MAKING OR NOT MAKING DISCLOSURES

Article 27-F specifically grants physicians (and their employers or health care providers with whom they are associated) immunity from liability for —

- failing to disclose HIV-related information to a protected individual's contact;

[272] 5 U.S.C.A. § 552a.
[273] 45 C.F.R. § 160.306(a).
[274] 42 U.S.C. § 1320d-5 *et seq.*
[275] 45 C.F.R. § 160.306(b).
[276] 45 C.F.R. § 160.308.
[277] 45 C.F.R. § 160.310.

- failing to disclose HIV-related information to a "person authorized pursuant to law to consent to health care" for a protected individual (usually a parent or guardian of a minor);
- disclosing HIV-related information to a "contact or a person authorized pursuant to law to consent to health care for a protected individual," when the disclosure is "carried out in good faith and without malice, and in compliance with [Article 27-F]"; and
- disclosing HIV-related information to "any person, agency, or officer authorized to receive such information, when carried out in good faith and without malice, and in compliance with [Article 27-F]".[278]

This provision explicitly recognizes that physicians have a good deal of discretion to disclose, or not to disclose, HIV-related information in a variety of circumstances. And it protects those physicians who exercise that discretion in good faith, in compliance with the law.

2. LIMITATIONS ON LIABILITY: HIV CASE REPORTING AND PARTNER NOTIFICATION

The HIV Reporting and Partner Notification Law also explicitly protects persons who, in good faith, conduct HIV/AIDS case reporting and contact notification activities authorized by the law, from any civil or criminal liability, including claims for libel, slander, or violation of the doctor-patient privilege.[279] This protection extends to physicians and other diagnostic providers mandated to report HIV/AIDS cases, as well as physicians and public health officials carrying out partner notification efforts.

[278] N.Y. Pub. Health Law § 2783(3)(a)-(c).
[279] N.Y. Pub. Health Law § 2136.

PART 3

PROTECTIONS AGAINST HIV-RELATED DISCRIMINATION

INTRODUCTION

Federal, New York State and New York City laws that prohibit discrimination based on an individual's "disability" forbid virtually all health and social service providers, as well as government agencies, from refusing to serve or discriminating in the provision of *services* to, and from discriminating in *employment* against, people because they have or are believed to have HIV disease, including HIV infection, any related illness or AIDS.

I. APPLICABLE LAWS AND BASIC RULES

A. NONDISCRIMINATION LAWS AND REGULATIONS

The laws that protect both clients and job applicants and employees from HIV-based discrimination include:

1. THE REHABILITATION ACT OF 1973

This federal law (sections 501, 503 and 504 of the Act, contained in 29 U.S.C. (United States Code) §§ 791 through 794) —

applies to:

- federal government agencies;[280]

[280] Section 501, codified at 29 U.S.C. § 791.

- any agency with federal contracts or subcontracts of $10,000 or more;[281] and
- any agency that receives federal grants or funding,[282] directly or indirectly.[283]

protects:

- individuals with a past, current or perceived "disability" who are qualified to receive the service or benefit, participate in the program or perform the job in question. Courts have ruled that individuals who are known or believed (even erroneously) to have HIV disease, including conditions from asymptomatic infection to AIDS, are persons with "disabilities" (defined in the same way as in the ADA, below).

2. THE AMERICANS WITH DISABILITIES ACT OF 1990 & THE ADA AMENDMENT ACT OF 2008

The Americans with Disabilities Act of 1990 (the "ADA"), 42 U.S.C. § 12101 et seq., is another federal anti-discrimination law. The ADA was amended by the ADA Amendment Act of 2008 (the "ADAAA"), which became effective January 1, 2009. When this manual uses the term "ADA," it refers to the ADA, as amended.

The nondiscrimination requirements of the ADA –––

apply to:

- public and private employers with 15 or more employees, employment agencies, and labor organizations; [284]
- all state and local governments and agencies of such governments (including government employers of any size); [285]
- places of "public accommodation" and other services operated by private entities, including hospitals, professional offices of health care providers (e.g., doctors, dentists, nurses), private schools, day care and other social service centers, hotels, restaurants, stores, etc.; [286] and
- public transportation[287] and telecommunications systems.[288]

protect:

- individuals with a past, present or perceived "disability," which is defined as:
  - » " a physical or mental impairment that substantially limits one or more major life activities of such individual";
  - » "a record of such an impairment"; or
  - » "being regarded as having such an impairment." [289]

[281] Section 503, codified at 29 U.S.C. § 793(a).
[282] Section 504, codified at 29 U.S.C. § 794(a).
[283] *Herman v. United Bhd. of Carpenters & Farmers of Am.*, 60 F.3d 1375, 1381 (9th Cir. 1995).
[284] Title I, 42 U.S.C. §§ 12101-12117.
[285] Title II, Part A, §§ 12131 -12134.
[286] Title III, 42 U.S.C. §§ 12181-12189.
[287] Title II, Part B.
[288] Title IV.
[289] 42 U.S.C. § 12102(1).

While the ADAAA did not change the three-category definition of "disability" under the ADA, it did add provisions to ensure that the law is applied expansively in order to protect individuals with disabilities.[290]

For example, "major life activities" contained within the first category now include (without limitation): "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending , speaking, breathing, learning, reading, concentrating, thinking, communicating, and working." [291] Importantly, "major life activity" also includes the operation of a major bodily function, including but not limited to, functions of the immune system . . . "[292]

According to the ADAAA, "[t]he determination of whether an impairment substantially limits a major life activity" is to be made "without regard to the ameliorative effects of mitigating measures," such as medication or a reasonable accommodation.[293] Moreover, "[a]n impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active."[294]

Another example is that an individual may now meet the definition of "being regarded as having an impairment" – the third category – by establishing that s/he was subjected to an action prohibited by the ADA "because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity."[295]

Therefore, now that the ADAAA is in effect, it should prove easier to establish that an individual with HIV (or an individual who is perceived to have HIV) is an "individual with a disability."[296] In fact, the EEOC's regulations implementing the ADAAA state "the individualized assessment of some types of impairments will, in virtually all cases, result in a determination of coverage" under the "actual disability" category or the "record of" category of disability.[297] As an example, the EEOC regulations provide that HIV infection, at a minimum, substantially limits the immune function (a major life activity).[298]

In the context of employment, Title I protects "qualified" individual with disabilities, which means individuals who, with or without reasonable accommodations, can perform the essential functions of the job.[299] With respect to state or local governmental services, programs, and activities, Title II, also protects "qualified" individuals with a disability, which means individuals

[290] Prior to the passage of the ADAAA, many people with disabilities had difficulty asserting claims under the ADA because of the restrictive manner in which federal courts had defined "disability." To remedy this, Congress passed the ADAAA. Congress noted that the ADAAA was specifically intended to reject the holdings in several Supreme Court decisions and portions of the United States Equal Employment Opportunities Commission's ("EEOC") ADA regulations that had an overly restrictive definition of "disability." Thus, the ADAAA emphasizes that the definition of "disability" should be "construed in favor of broad coverage of individuals . . . to the maximum extent permitted by the terms of [the ADA]" and that the determination of "whether an individual's impairment is a disability under the ADA should not demand extensive analysis." 42 U.S.C. § 12102(4)(A); 42 U.S.C. §12101(5) (ADAAA Findings and Purposes).

[291] 42 U.S.C. § 12102(2)(A).

[292] 42. U.S.C. § 12102(2)(B).

[293] 42 U.S.C. § 12102(4)(E)(i)(I).

[294] 42 U.S.C. § 12102(4)(D).

[295] 42 U.S.C. § 12102(3)(A) (emphasis added).

[296] Even prior to the enactment of the ADAAA, courts, including the U.S. Supreme Court, have concluded that HIV is a covered disability even in cases of asymptomatic HIV infection.

[297] 29 C.F.R. § 1630.2(j)(3)(ii).

[298] 29 C.F.R. § 1630.2(j)(3)(iii).

[299] 42 U.S.C. §§ 12112(a), 12111(8).

who, with or without reasonable modifications to rules, policies or practices, meet the essential eligibility requirements for the receipt of services or participation in the program in question.[300] With respect to public accommodations such as private health or social service providers, Title III protects individuals with disabilities from being discriminated against on the basis of disability in the "full and equal enjoyment" of the services or public accommodation in question.[301] As in other titles of the ADA (as amended), a public accommodation is required to make reasonable modifications in its policies, practices or procedures when necessary to provide the particular services.

The ADA (as amended) also protects individuals who are subjected to discrimination in employment, in receipt of public services and by public accommodations because of their association with an individual with a disability.[302]

3. THE NEW YORK STATE HUMAN RIGHTS LAW

This state law (N.Y. Exec. Law §§ 290 et seq.) —

applies to:

- public and private employers (with 4 or more employees);[303]
- places of public accommodation[304] (including hospitals, clinics and most other health care providers that offer their services to the public); and
- most housing providers and social service providers.[305]

protects:

- individuals with a past, present or perceived "disability," which is generally defined as "a physical, mental or medical impairment" and, in the context of employment, means a condition that does not interfere with the person's ability (with or without reasonable accommodations) to perform the job requirements in a "reasonable manner."[306] Many cases brought under this law, including those decided by the state's highest court (the Court of Appeals), have confirmed the law's protection of individuals who are known or believed (even erroneously) to have HIV infection or any related illness.

4. THE NEW YORK CITY HUMAN RIGHTS LAW

This New York City law (N.Y.C. Admin. Code, Article 8, §§ 8-102, 8-107) —

applies to:

- public and private employers (with 4 or more employees); [307]
- public accommodations[308] (including virtually all health care and human service providers); and

[300] 42 U.S.C. §§ 12132, 12131(2).
[301] 42 U.S.C. § 12182(a).
[302] 42 U.S.C. § 12112(b)(4).
[303] N.Y. Exec. Law § 292(5).
[304] N.Y. Exec. Law § 296(2).
[305] *See, e.g.,* N.Y. Exec. Law § 296(2-a), 3-b), (5), (18).
[306] N.Y. Exec. Law § 292(21).
[307] N.Y.C. Admin. Code § 8-102(5).
[308] N.Y.C. Admin. Code § 8-107(4).

- most public and private housing providers in New York City.[309]

protects:

- individuals with an actual or perceived "disability" – defined generally as any "physical, medical, mental or psychological impairment, or a history or record of such impairment" [310]— which, courts have repeatedly ruled, includes those known or believed (even erroneously) to have HIV/AIDS.

5. ARTICLE 27-F OF THE NEW YORK STATE PUBLIC HEALTH LAW (HIV TESTING AND CONFIDENTIALITY LAW)

While Article 27-F primarily deals with HIV-related testing and confidentiality, it also requires state agencies that serve or monitor the provision of services to individuals with HIV/AIDS to issue regulations to "provide safeguards to prevent discrimination, abuse or other adverse actions" against such clients.[311] The nondiscrimination requirements of this law and state agencies' regulations implementing it —

apply to:

- all state agencies that obtain HIV-related information in accordance with Article 27-F, and all health care and social service providers that are funded, regulated or monitored by those state agencies.

protect:

- individuals who have been tested for or diagnosed with HIV/AIDS.

6. THE FAIR HOUSING AMENDMENTS ACT OF 1988

The federal Fair Housing Act (42 U.S.C. §§ 3601-3619) makes discrimination in housing and real estate transactions illegal when it is based on "handicap" (as well as when it is based on race, religion, national origin or sex). The law —

applies to:

- most public and private housing providers and other entities involved in the sale or rental of housing, and other housing practices.

protects:

- individuals with a "handicap" [312] (defined the same way as "disability" in the Rehabilitation Act and ADA), entities that provide housing for people with disabilities, and individuals subjected to discrimination in housing practices because of their association with people with disabilities.

B. BASIC NONDISCRIMINATION REQUIREMENTS

The nondiscrimination laws outlined above establish two basic rules:

- Do not discriminate against any individual on the basis of his or her suspected or known HIV status; and

[309] *See, e.g.,* N.Y. Admin. Code 8-107(5).
[310] N.Y.C. Admin. Code § 8-102(16)(a).
[311] N.Y. Public Health Law § 2786(2)(a).
[312] 42 U.S.C. § 3602(h).

- Be prepared to offer "reasonable accommodations" to those with HIV-related conditions who may need such accommodations in order to participate in the program, benefits or services in question or to perform the duties of their job.

Each of these concepts is discussed below, as they apply to client services (Section II) and to job applicants and employees (Section III).

II. CLIENT ISSUES

A. NONDISCRIMINATION

1. GENERAL RULE: NO DISCRIMINATION

Under the federal, state and city nondiscrimination laws, health and human service agencies may not deny admission or services or discriminate in the provision of care or services to any individual because of that person's known or suspected HIV status. Under the state and city Human Rights Laws, it is also illegal to discriminate against individuals because of their membership in a group that is believed to be at risk for HIV, or because of their association with persons known to have HIV disease. Under the ADA, providers that serve people with HIV/AIDS cannot be subjected to discrimination because of their association with these people.

2. PARTICULAR APPLICATIONS

a. ADMISSION/ELIGIBILITY CRITERIA

People with known or suspected HIV disease must be considered for admission/receipt of services, on a case-by-case basis, in accordance with the provider's usual stated criteria for admission/receipt of services. Individuals who meet the essential eligibility requirements for the agency's services, and who are currently able to participate in and benefit from the agency's services, are entitled to receive them. Any reasonable accommodations (discussed below) needed to enable a person to participate in a program of services must be made.

It is generally not permissible for health or social service agencies to refuse, limit or provide different, lesser services to individuals known or believed to have HIV disease because of the possibility that in the future their illness may make them unable to participate in or benefit from the agency's program of services.

b. HIV TESTING/DISCLOSURE OF HIV STATUS

Asking or requiring a person to undergo HIV testing or to disclose his or her HIV status as a condition of receiving services is likely to violate federal, New York State and New York City nondiscrimination laws, if the purpose of eliciting information about a person's HIV status is to use that information to deny or give that person different services than others. (A testing requirement also violates Article 27-F of the Public Health Law; see Part 1.)

Therefore, in general, no applicant for or recipient of services may be asked or required to undergo HIV testing, to state whether he has undergone HIV testing, or to disclose his HIV status, as a condition of admission or continued receipt of services. The exception is when having HIV/AIDS is itself a condition of eligibility, as with programs of services that are available only to those with HIV disease; it is legal for these programs to require confirmation of an individual's HIV status.

c. SEGREGATION/DIFFERENTIAL TREATMENT OF CLIENTS WITH HIV

Because HIV is not transmitted through casual contact, in the vast majority of settings (including residential settings) there is no medical or legal justification for segregating or treating differently clients with HIV/AIDS or those believed to be infected. Even in health care settings, where the performance of certain duties by health care workers may create some risk of exposure to HIV (e.g., invasive procedures with the potential for blood-to-blood contact), health authorities require the use of universal precautions — rather than identification and segregation of patients — as the most effective way of reducing the risk of occupational exposure to HIV and other bloodborne diseases.

Segregation or differential treatment for the purpose of protecting others — clients or staff —from possible HIV transmission is therefore generally illegal discrimination. There are other, effective, nondiscriminatory means of protecting staff and clients from potential exposure to HIV. These include —

- educating both clients and staff (without regard to whether any individual's HIV status is known) about the nature of HIV and AIDS, the ways in which the virus is transmitted, the behaviors that create a risk of transmission, and the preventive practices that eliminate or effectively reduce that risk; and
- implementing and requiring clients and staff to comply on site with basic hygienic measures and appropriate universal infection control precautions, without regard to whether any client's or employee's HIV status is known.

Health and social service providers that are covered under regulations implementing the state's HIV Testing and Confidentiality Law (Article 27-F) must implement and enforce plans for preventing and managing potential exposures to HIV ("infection control plans"). Thus, a health or social service agency that responded to HIV/AIDS by segregating or selectively discriminating against clients identified as having or being at risk for HIV — rather than by implementing appropriate, across-the-board precautions for preventing transmission — could face potential liability on two counts: for violating the mandate of applicable state regulations and applicable nondiscrimination laws.

B. REASONABLE ACCOMMODATIONS

1. RULE: REASONABLE ACCOMMODATIONS MUST BE MADE

The federal, New York State and New York City nondiscrimination laws require health and human service agencies to make reasonable accommodations to the known disabilities of clients and applicants for services, when necessary to afford the individual access to the service. However, accommodations that would cause the agency undue financial hardship or require it to change the basic, fundamental nature of its services are not required.

a. WHAT ARE REASONABLE ACCOMMODATIONS?

Reasonable accommodations are adjustments in the agency's program of services, or its policies and procedures, that are necessary so an individual can participate fully and equally in those services. For example —

- a counseling agency could schedule a client's appointments in a way that enables the client to make other necessary medical care appointments.
- agencies that ordinarily require face-to-face meetings with their clients could make exceptions for homebound or hospitalized clients, or those whose health makes it difficult to make regular appointments at the agency.

b. WHAT IS NOT REQUIRED

Accommodations that would cause the agency undue financial hardship or require it to change the fundamental nature of its services are not required. For example —

- an agency that never makes home visits to clients, and does not have the human or financial resources to do so, need not develop a home-visit program to continue serving clients with HIV-related illnesses.
- a residential housing or treatment program that has never provided on-site medical services to residents need not develop on-site medical care for people with HIV-related illnesses.

2. HOW TO ASSESS REASONABLE ACCOMMODATIONS

The need for and nature of the reasonable accommodations to be arranged for any client should be assessed and decided on a case-by-case basis, and should be a decision resulting from an interactive process between the client and provider. The provider should —

- designate appropriate agency personnel to be responsible for assessing a client's need for and arranging appropriate reasonable accommodations;
- tell all clients (not only those known or believed to have HIV disease) that the agency will make reasonable accommodations when clients' medical conditions require them;
- encourage (but not require) clients who believe they need accommodations to come forward and talk to designated agency personnel about their needs;
- refrain from requiring clients to disclose their specific diagnoses as a condition of considering whether, and what, reasonable accommodations may be necessary. Instead, focus on identifying the specific limitations imposed by the individual's condition, including those caused by medications or other side effects from treatment. (Verification that a client has a disability requiring accommodations, and details about the limitations it creates, may be sought, for example, from the client's primary health care provider, without requiring disclosure of the specific diagnosis.);
- decide on appropriate accommodations through an interactive process with the client, and give each client the opportunity to identify the accommodations that will work best for her, rather than imposing the agency's own view of what is needed (though the agency, not the client, makes the final decision);
- document the request, needs assessment, and specific accommodation(s) offered and/or arranged; and
- strictly protect the confidentiality of any HIV-related information that is disclosed by or obtained about any client (in this connection, see Part 2).

III. EMPLOYMENT ISSUES

A. NONDISCRIMINATION

In the context of employment (as with client services), the nondiscrimination laws cited above establish the same two cardinal rules:

- do not discriminate against any job applicant or employee on the basis of his or her known or suspected HIV status; and
- be prepared to provide reasonable accommodations to such individuals, when needed.

1. GENERAL RULE: NO DISCRIMINATION

Under federal, New York State and New York City nondiscrimination laws, it is illegal for an employer to refuse to hire, fire or discriminate in the terms or conditions of employment against any job applicant or employee because that person has or is perceived as having any HIV-related condition, if that person is qualified and can (with or without reasonable accommodations, as discussed below) perform the essential functions of the job in question.

These laws are all designed to ensure that employment decisions are made on the basis of job-related criteria — ones that measure an individual's actual ability to perform the duties of a particular job — not on the basis of their known or suspected HIV status.

Employers covered by the federal nondiscrimination laws may require that individuals not pose a "direct threat" to "the health or safety of other individuals in the workplace."[313] A direct threat means "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation."[314] (The New York State and New York City Human Rights Laws establish similar standards.) Because HIV is not transmissible through casual contact or through any of the activities involved in the performance of the vast majority of jobs, courts have found that the fact that an applicant or employee has HIV disease poses no risk that would justify an employer's exclusion or differential treatment of such a person in most workplaces.[315]

The agencies that enforce the New York State and New York City Human Rights Laws have taken the position that those laws also protect individuals from being subjected to job discrimination because they are members of a group perceived to be at risk for HIV, or because of their relationship or association with others known or believed to have HIV/AIDS. Similarly, the federal ADA explicitly prohibits job discrimination against a person because of her association with someone with a disability, including HIV disease, known to the employer.

[313] 42 U.S.C. § 12113(b).

[314] 42 U.S.C. § 12111(3).

[315] A small number of positions do involve the performance of duties where a potential risk of HIV transmission may exist (e.g., certain health care workers perform invasive procedures with a potential for blood-to-blood contact). But if such a risk could be eliminated by reasonable accommodation, an employer may not deny an individual employment on the basis of disability. This assessment must be made on an individualized basis; a blanket policy of excluding HIV-positive persons from all jobs as nurses or physicians, for example, is likely illegal.

2. PARTICULAR APPLICATIONS

a. EXAMPLES OF DISCRIMINATORY POLICIES AND PRACTICES

The following employment policies or practices constitute illegal discrimination under one or more of the nondiscrimination laws outlined here:

- a policy of excluding applicants or employees from employment, or from particular jobs, because they are known or believed to have HIV/AIDS.
- using qualification standards that screen out or tend to screen out individuals with HIV/AIDS, unless those standards are job-related.
- not making reasonable accommodations to the known physical or mental limitations of an applicant or employee with HIV/AIDS who is otherwise qualified for and would be capable of performing the job if provided the accommodation, unless the employer shows that the accommodation would impose an undue hardship (see below, at pages 97-98).
- limiting, segregating, or treating an employee with HIV/AIDS in a way that adversely affects his status or opportunities on the job because of his disability.
- refusing to hire or retain an individual with HIV disease because of concerns that her illness may in the future impair her capacity to perform the job.
- refusing employment opportunities to an individual with HIV/AIDS on the basis of the employer's (or co-workers' or clients') fears of "contagiousness."

b. PRE-EMPLOYMENT INQUIRIES AND MEDICAL EXAMINATIONS; HIV TESTING

Requiring a job applicant to disclose his or her HIV status or to undergo an HIV test (or other medical examination) as a condition of employment is generally illegal under the nondiscrimination laws cited above. Employers may ask job applicants questions relating to their ability to perform job-related functions. They generally may not, however, make pre-employment inquiries about whether an applicant has a particular disability (including HIV/AIDS) or about the nature or severity of such a disability.

Under New York State Human Rights Law, employers may not require a job applicant to undergo a medical examination, including an HIV test, as a condition of employment, unless based upon a bona fide occupational qualification — a qualification standard that is job-related and material to job performance. (HIV testing by employers could also be challenged as a violation of Article 27-F of the Public Health Law; see Part 1.)

The federal nondiscrimination laws also prohibit covered employers from requiring applicants to undergo a medical examination before an offer of employment is made. After making a job offer to an individual, though, these employers may make medical inquiries and/or require the individual to undergo a medical examination before beginning the job; and the employer may condition the job offer on the satisfactory results of such medical exams or inquiries, but only if —

- all entering employees (or all employees in a particular job category) are subjected to the examination/inquiry;

- the information obtained as a result of the medical examination is kept strictly confidential (see "Confidentiality in the employment context," at page 98; and
- the information is not used to deny employment to or otherwise discriminate against an individual who is qualified to perform the job (or would be, if reasonable accommodations were made).

c. EMPLOYEE MEDICAL EXAMINATIONS OR INQUIRIES

Under the federal nondiscrimination laws, an employer may not require employees to undergo medical examinations (including HIV tests), or to disclose whether they have a disability or the nature or severity of a disability, unless such a medical examination or inquiry is shown to be job-related and consistent with business necessity. (The New York State and New York City Human Rights Laws have been interpreted to have comparable restrictions.)

Employers may inquire into the ability of an employee to perform job-related functions. They may also conduct voluntary medical examinations as part of a health program available at the worksite. But information obtained through these activities must be kept strictly confidential and may not be used to discriminate (see page 98).

B. REASONABLE ACCOMMODATIONS

1. GENERAL RULE: REASONABLE ACCOMMODATIONS MUST BE MADE

The federal and New York State and New York City laws require employers to make reasonable accommodations to the known physical or mental limitations of job applicants and employees with disabilities (including HIV/AIDS) —

- if the individual is otherwise qualified and the accommodation would enable the individual to perform the essential duties of the job,
- unless the accommodation would impose an "undue hardship" on the operations of the employer.

Under these laws, it is illegal for an employer to fail or refuse to make reasonable accommodations, or to deny an individual employment opportunities when the denial is based on the need to make reasonable accommodations.

a. WHAT ARE REASONABLE ACCOMMODATIONS?

Reasonable accommodations are adjustments or modifications in an employment setting that are necessary to enable an applicant or employee who is otherwise qualified for a job (i.e., who would be able to perform the job if the accommodation were made) to perform the essential duties and functions of the job. Possible reasonable accommodations include —

- job restructuring, part-time or modified work schedules; for example —
  - » granting the request of an employee with HIV disease to work a constant shift, to accommodate his need for regular rest,

even though most employees work rotating shifts.

  - » allowing an employee to work flexible hours or modify her work schedule to accommodate her need to make medical appointments or receive other treatment or counseling during regular working hours.
  - » granting an employee's request for additional unpaid leave days;
- appropriate modifications of examinations, training material, or policies;
- making existing worksites readily accessible to and usable by individuals with disabilities;
- modification of equipment or provision of qualified readers or interpreters; or
- reassigning an employee to a vacant position for which he is qualified.

b. WHAT IS NOT REQUIRED

An employer need not make accommodations that would impose an "undue hardship" on its operations. An undue hardship means significant difficulty or expense for the employer.

Whether a particular accommodation would result in undue hardship must be determined on a case-by-case basis, taking into account such factors as the nature and cost of the needed accommodation, the overall financial resources and size of the employer, the nature and type of the employer's operations, and the impact of the needed accommodation on the employer's operations. For example —

- a small day care center with three staff members would not necessarily be required to provide an indefinite unpaid leave to an ill employee, if that would seriously impair its ability to provide adequate services to clients.
- if an employee holds a position that must be performed on a full-time basis, and she develops an illness that prevents her from continuing to work a forty-hour week, the employer would not be required to retain her on a part-time basis and hire an extra employee to ensure that the position is performed full-time.

2. HOW TO ASSESS REASONABLE ACCOMMODATIONS

The need for and nature of the reasonable accommodations for any individual with HIV must be assessed and decided on a case-by-case basis, through an interactive process between the employer and the employee. The employer should establish the same kinds of reasonable accommodation policies and procedures with respect to employees as are outlined above for clients (see page 97).

3. CONFIDENTIALITY IN THE EMPLOYMENT CONTEXT

Employers must maintain the confidentiality of any medical information (including HIV-related information) that is obtained about the job applicant or employee.

Under the federal nondiscrimination laws cited above, any information obtained by an employer subject to those laws about the medical history or condition of job applicants and employees must be kept strictly confidential, and must be maintained on separate forms and in separate medical files. The ADA specifies that the only individuals who may have access to the information are:

- supervisors and managers who need to be informed about necessary work restrictions and necessary accommodations;
- first aid and safety personnel who may be informed when appropriate if the disability might require emergency treatment; and
- government officials investigating compliance with those discrimination laws.[316]

Note, though, that if an employee tells co-workers about his HIV status, or co-workers learn about it from someone other than from the employer, no confidentiality law prohibits those co-workers from telling others. But if discrimination in the workplace results from these disclosures, including where the employer takes action against the employee because of the worker's HIV status, the employee suffering from these adverse actions can claim the protection of the laws forbidding discrimination.

[316] 42 U.S.C. § 12112(d)(3)(B).

IV. REMEDIES FOR DISCRIMINATION

The federal, New York State and New York City nondiscrimination laws generally offer both administrative and judicial remedies.

A. REHABILITATION ACT OF 1973

1. REMEDIES

Remedies for violations of the federal Rehabilitation Act include equitable relief (orders making defendants do or refrain from doing something) and (as of the date this manual is published) compensatory damages (money to compensate a person for actual harms caused by the discrimination).[317] In employment cases, equitable relief may include hiring or reinstatement and back pay, and orders to provide reasonable accommodations to an employee. In cases involving discrimination in the provision of benefits or services to clients, equitable relief may include orders not to discriminate, to modify policies or practices, or to provide reasonable accommodations.

2. ADMINISTRATIVE COMPLAINT/LAWSUIT PROCESS

Claims against recipients (public or private) of federal grants or aid. Individuals claiming discrimination in employment or services by an agency that receives federal grants or aid other than federal contracts have the right to file an administrative complaint or a lawsuit — or both — under section 504 of the Rehabilitation Act (29 U.S.C. § 794).

- Administrative complaints may be filed with the federal agency that funds the discriminating agency or with the U.S. Department of Justice in Washington, D.C., which will refer the complaint to the proper federal agency. People do not need a lawyer to do this. To learn how and where to file administrative complaints, under the Rehabilitation Act as well as the ADA, call the Department of Justice's ADA Information Line (800-514-0301). The time limit for filing such complaints is 180 days from the date of the discrimination.
- Lawsuits may also be filed in federal or state court and, in New York, must be filed within three years after the discriminatory act. Individuals need not go through the administrative complaint process before going to court.

Job discrimination by federal contractors or federal employers may be challenged in an administrative complaint filed with (1.) the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP), if the discriminating agency is a federal contractor;

[317] Rehabilitation Act § 505, 29 U.S.C. § 794a.

the time limit is 180 days[318]; or (2.)the equal opportunity office of the discriminating employer, if a federal employer is the discriminating agency;[319] the time limit for beginning the complaint process is 45 days after the discriminatory act.[320]

- Persons challenging discrimination by federal employers under Section 501 of the Rehabilitation Act may also file lawsuits in court, but must first go through the administrative complaint process with the employer's equal opportunity office.
- Discrimination by federal contractors in violation of Section 503 of the Act may only be redressed through the administrative process in the OFCCP.

B. AMERICANS WITH DISABILITIES ACT

Individuals claiming violations of the ADA also have a choice of filing administrative complaints or lawsuits (in federal or state court), although the available remedies may differ depending on the nature of the discrimination involved.

1. REMEDIES

Job discrimination. Remedies for employment discrimination in violation of Title I of the ADA include equitable relief (hiring, reinstatement and back pay, or orders to provide reasonable accommodations to an employee) and monetary relief.[321] Money damages are not available to those suing state agencies for job discrimination under Title I (and, most likely, Title II), but are available against private employers, and (as of the time this manual is published) when the employer is a county or city governmental agency.

State/local government programs, benefits, or services. State and local governmental agencies' discriminatory actions and policies that violate Title II of the ADA can be remedied through equitable relief and monetary damages.[322]

Public accommodations (private agencies' services or programs). Remedies for discrimination against clients by public accommodations under Title III — including private health or social service providers — can include equitable relief (including orders to prevent discrimination, to modify a policy or practices, to provide auxiliary aids or services, or to make a facility accessible to those with disabilities), and civil penalties (fines) under certain circumstances. Money damages are not available to individuals who file lawsuits, but may be obtained if the U.S. Attorney General decides to bring a lawsuit challenging discrimination by a public accommodation and requests such damages.[323]

[318] Section 503 of the Rehabilitation Act, 29 U.S.C. § 793.
[319] Section 501 of the Act, 29 U.S.C. § 791.
[320] 29 C.F.R. § 1614.105(a)(1).
[321] Title I, 42 U.S.C. § 12117.
[322] Title II, 42 U.S.C. § 12133.
[323] Title III, 42 U.S.C. § 12188.

2. ADMINISTRATIVE COMPLAINT/LAWSUIT PROCESS

Private employment. Individuals claiming discrimination by private employers under Title I must file an administrative complaint with the federal Equal Opportunity Employment Commission (EEOC). (Call the EEOC at 1-800-669-4000 for information about EEOC offices and procedures.) The ADA complaint can be filed directly with the EEOC or with the State Division of Human Rights or New York City Commission on Human Rights.

- The deadline for filing these administrative complaints in New York is 300 days after the discriminatory act if the complaint is filed first in the state or city human rights agency — which can process complaints alleging violations of the ADA as well as of New York's nondiscrimination laws (see page 103). If the state or city agency decides to stop processing an ADA complaint that was initially filed with it, it will notify the complainant, who must then file the complaint with the EEOC within 30 days after the state or city agency has stopped processing it. The deadline for individuals who do not initially file their ADA complaint with the state or city human rights agency, however, is only 180 days from the date of the discrimination.
- Lawsuit. If the claim is not resolved in the EEOC or the EEOC determines that discrimination did not occur, the complainant will receive a notice of the right to file a lawsuit in court. That suit must be filed within 90 days of receiving the notice.

State/local government employment. Discrimination complaints against public (government) employers under Title II, however, can be filed in court without first filing an administrative complaint.[324] Because Title II does not have a statute of limitations for private lawsuits against public employers, courts typically adopt the most analogous statute of limitations under state law. Under New York state law, such a lawsuit against a public employer that is filed directly in court (bypassing the EEOC process) must be filed within three years of the discrimination.

Government programs, services or activities. Discrimination complaints against a state or local government, under Title II, may be filed directly in court or as an administrative action. Administrative complaints may be filed with either the federal agency that has authority over the government function at issue in the case or with the Civil Rights Division of the U.S. Department of Justice, which will transfer the complaint to the correct federal agency. The ADA Information Line can provide assistance on filing a complaint (call 800-514-0301). The deadline for filing an administrative complaint is within 180 days of the discriminatory act. Under New York state law, complaints may also be filed directly in court (without going through the administrative process) within three years of the discrimination.

Public accommodations. People claiming discrimination by public accommodations including private health or social service providers, under Title III, may also file either an administrative complaint with the Civil Rights Division of the U.S. Department of Justice or file a lawsuit in court (within three years from the date of discrimination under New York state law). They need not go through the administrative complaint process first.

[324] 28 C.F.R. § 35.172(d).

C. NEW YORK STATE HUMAN RIGHTS LAW

Remedies for State Human Rights Law violations include equitable relief and money damages to compensate individuals for harms caused by the discrimination.[325] People may file administrative complaints with the State Division of Human Rights (SDHR), the state agency charged with enforcing this law, or file a lawsuit in state court — not both.

1. ADMINISTRATIVE COMPLAINTS.

The SDHR has offices around the state and has a toll free number to deal with discrimination complaints (1-888-392-3644). The process is easy and individuals do not need lawyers. The time limit for filing complaints with the SDHR is one year from the date of the discriminatory act[326]

- Lawsuits may be filed within three years of the discriminatory act. People need not file a complaint first with the SDHR.

D. NEW YORK CITY HUMAN RIGHTS LAW

Remedies for violations of the New York City Human Rights Law include equitable relief and compensatory or punitive damages (for acts of discrimination occurring in New York City).[327] The city's law, like the state's, gives individuals the choice of either filing a lawsuit in state court or filing an administrative complaint with the New York City Commission on Human Rights (but not both).

1. ADMINISTRATIVE COMPLAINTS

The Commission has a telephone number for discrimination complaints (212-306-7450) and currently accepts walk-ins from 9:00 to 3:30 (NYC Human Rights Commission, 40 Rector Street (10th floor), 10006; web site - http://www.nyc.gov/html/cchr/html/howto.html). The deadline for filing complaints with the Commission is one year after the discriminatory act occurred.[328]

- Lawsuits must be filed within three years from the date of discrimination.[329] People do not need to file complaints with the Commission before going to court, but must notify authorized representatives of the Commission and the New York City Corporation Counsel within ten days after commencing the lawsuit.[330]

E. ARTICLE 27-F OF THE NEW YORK STATE PUBLIC HEALTH LAW

As noted previously (on page 90), the state's HIV Testing and Confidentiality Law does not itself establish remedies for discrimination. But if HIV testing or a disclosure of confidential HIV-related information results in discrimination in violation of the federal, state or New York City

[325] N.Y. Exec. Law § 297.
[326] N.Y. Exec. Law § 297(5).
[327] N.Y.C. Admin. Code §§ 8-109, 8-502.
[328] N.Y.C. Admin. Code § 8-109(e).
[329] N.Y.C. Admin. Code § 8-502(d).
[330] N.Y.C. Admin. Code § 8-502(c).

nondiscrimination laws, that individual may seek administrative and/or judicial remedies for discrimination.

In addition, the state agency regulations implementing Article 27-F prohibit health and social service providers subject to that law, and their staff, from discriminating or otherwise taking adverse action against clients or staff with HIV/AIDS.[331] Agency staff who violate the nondiscrimination requirements of these regulations are subject to disciplinary action, up to and including termination. Clients or staff of such providers who believe they are being mistreated or discriminated against for this reason may, therefore, notify the agency's administrators so that appropriate disciplinary action may be taken. They may also file complaints with the Special Investigation Unit of the Department of Health's AIDS Institute (see page 82).

F. FAIR HOUSING AMENDMENTS ACT OF 1988

Remedies for violations of the federal Fair Housing Act include equitable relief, monetary damages and/or civil penalties (42 U.S.C. §§ 3612, 3613(c)).

- Administrative complaints may be filed with the U.S. Department of Housing and Urban Development (HUD), within one year after the discrimination occurred.[332] The Attorney General of the United States also has the authority to monitor and redress housing discrimination under this law.[333]
- Lawsuits may be filed in federal or state court within two years of the discriminatory act.[334] Persons may pursue both administrative and judicial remedies for such discrimination and need not go through the administrative process before going to court.

A FINAL NOTE: SEE APPENDIX H FOR A LIST OF LEGAL RESOURCES FOR PEOPLE WITH HIV-RELATED QUESTIONS OR PROBLEMS.

[331] N.Y. Pub. Health Law § 2786(2)(a).
[332] 42 U.S.C. §§ 3610, 3613.
[333] 42 U.S.C. § 3614.
[334] 42 U.S.C. §§ 3610, 3613.

NEW YORK STATE DEPARTMENT OF HEALTH
AIDS Institute

HIV-Specific Model Consent Form

Informed Consent to Perform HIV Testing

My health care provider has answered any questions I have about HIV/AIDS. I have been provided information with the following details about HIV testing:

- HIV is the virus that causes AIDS and can be transmitted through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV; contact with blood as in sharing needles (piercing, tattooing, drug equipment including needles), by HIV-infected pregnant women to their infants during pregnancy or delivery, or while breast feeding.
- There are treatments for HIV/AIDS that can help an individual stay healthy.
- Individuals with HIV/AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or being infected themselves with different strains of HIV.
- Testing is voluntary and can be done anonymously at a public testing center.
- The law protects the confidentiality of HIV test results and other related information.
- The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences.
- The law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

I agree to be tested for HIV infection. If the results show I have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time. If I test positive for HIV infection, I understand that my health care provider will talk with me about telling my sex or needle-sharing partners of possible exposure.

I may revoke my consent orally or in writing at any time. As long as this consent is in force, my provider may conduct additional tests without asking me to sign another consent form. In those cases, my provider will tell me if other HIV tests will be performed and will note this in my medical record.

Patient Name: _____ Date: _____

Signature: _____
Patient or person authorized to consent

Medical Record #: _____

DOH-2556 (1/11)

NEW YORK STATE DEPARTMENT OF HEALTH
AIDS Institute

Model for General Medical Consent that Includes Written Consent for HIV Testing

Use Sample A OR Sample B

Sample A – Consent for Medical Treatment

Use your facility's general medical consent but amend to include the following:

I have been given information regarding HIV testing, how HIV can be transmitted, that there is treatment for HIV/AIDS, how to keep myself and others safe from HIV infection, that testing is voluntary and can be done anonymously, how my HIV-related information will be kept confidential and what laws protect people with HIV/AIDS from discrimination. I understand that the results will be documented in my medical chart.

Consent for HIV-related testing remains in effect until I revoke it, or until the following date _____.

I may revoke my consent orally or in writing at any time. As long as this consent is in force, _____(provider name or facility)_____ may conduct additional tests on me without asking me to sign another consent form. In those cases, my provider will tell me if other HIV tests will be performed and will make a note in my medical record.

Patient Name: _____ Date: _____

☐ I do not want an HIV test

Signature: _____
Patient or person authorized to consent

Sample B – Consent for Medical Treatment

Use your facility's general medical consent but amend to include the following:

I have been provided information about HIV and I accept testing,

☐ No, I don't want an HIV test at this time.

Signature: _____
Patient or person authorized to consent

DOH-5019 (1/11)

NEW YORK STATE DEPARTMENT OF HEALTH
AIDS Institute

Model Form for Documenting Offer of HIV Testing

Sample – Offer of HIV Testing

Your health care provider is required to make an offer of HIV testing to all persons between the ages of 13 and 64 regardless of apparent risk. You are strongly encouraged to accept testing since, as with other medical screenings, it may provide you with important informatin about your health and give you what you need to make good decisions for staying healthy.

☐ Yes, I accept the offer of HIV testing.

☐ No, I don't want an HIV test today

Patient Name: _____ Date: _____

Signature: _____
Patient or person authorized to consent

DOH-5020 (1/11)

NEW YORK STATE DEPARTMENT OF HEALTH
AIDS Institute

Informed Consent to Perform HIV Testing and Authorization for Release of HIV-related Information for Purposes of Providing Post-exposure Care to a Health Care Worker Exposed to a Patient's Blood or Body Fluids

An employee has been exposed to your blood or a body fluid in a manner which may pose a risk for transmission of a blood-borne infection. Many individuals may not know whether they have a bloodborne infection because people can carry these viruses without having any symptoms. We therefore are asking for consent to test you for the presence of human immunodeficiency virus (HIV), the virus that causes AIDS. You will also be tested for hepatitis B virus (HBV) and hepatitis C virus (HCV).

Under New York State law, HIV testing is voluntary and requires consent in writing (consent can be withdrawn for testing at any time.) There are a number of tests that can be done to show if you are infected with HIV. Your provider or counselor can provide specific information on these tests. Anonymous testing is available at selected sites. These tests involve collecting and testing blood, urine or oral fluid. Additional testing also will tell whether you are carrying HBV or HCV.

HIV Testing is Important for Your Health

- If your test result is negative, you can learn how to protect yourself from being infected in the future.
- If your test result is positive:
  - You can take steps to prevent passing the virus to others.
  - You can receive treatment for HIV and learn about other ways to stay healthy. As part of treatment, additional tests will be done to determine the best treatment for you. These tests may include viral load and viral resistance tests.
- An infected mother can pass HIV to her child during pregnancy or birth or through breastfeeding.
- If you are pregnant and have HIV, treatment is available for your own health and to prevent passing HIV to your baby. If you have HIV and do not get treatment, the chance of passing HIV to your baby is one in four. If you get treatment, your chance of passing HIV to your baby is much lower.

If You Test Positive:

State law protects the confidentiality of your test results and also protects you from discrimination based on your HIV status.

- In almost all cases, you will be asked to give written approval before your HIV test can be shared.
- Your HIV information can be released to health providers caring for you or your exposed child; to health officials when required by law; to insurers to permit payment; to persons involved in foster care or adoption; to official correctional, probation and parole staff; to emergency or health care staff who are accidentally exposed to your blood; or by special court order.
- The names of persons with HIV are reported to the State Health Department for tracking the epidemic and for planning services.
- The HIV Confidentiality Hotline at 1-800-962-5065 can answer your questions and help with confidentiality problems.
- The New York State Division of Human Rights at 1-800-523-2437 can help if you think you've been discriminated against based on your HIV status.

If you are positive, your counselor/doctor will talk with you about notifying your sex or needle-sharing partners of possible exposure to HIV.

- Your partners need to know that they may have been exposed to HIV so they can be tested and get treated if they have HIV.
- If your health care provider knows the name of your spouse or other partner, he or she must report the name to the health department unless it would result in harm to you.
- Health department counselors can help notify your partner(s) without ever telling them your name.
- To ensure your safety, your counselor or doctor will ask you questions about the risk of domestic violence for each partner to be notified.
- If there is any risk, the Health Department will not notify partners right away and will assist you in getting help.

You are also being asked to authorize the release of confidential HIV-related information related to this consent for testing to the health professional, named below, who is treating the health care worker that has been exposed to your blood or body fluid. This is necessary to provide appropriate care and to counsel the worker about his or her risk of becoming infected and possibly infecting others. Under New York State law HIV-related information can only be given to people you allow to have it by signing a written release, except in the instances outlined above. These individuals are prohibited by law from re-disclosing testing results in a way that could reveal your identity.

Name and address of facility/provider disclosing HIV-related information: _____

_____

_____

Name and address of facility/provider to be given HIV-related information: _____

_____

_____

Describe information to be released: **HIV, HBV and HCV Test Results**

Time period during which release of information is authorized From: _____ To: _____

You may revoke this release, but disclosures cannot be revoked, once made. Additional exceptions to the right to revoke this release, if any: _____

_____

_____

Describe consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligibility for benefits. (Note: Federal privacy regulation may restrict some consequences): _____

_____

_____

I understand that I am being asked to submit a specimen for HIV testing for occupational exposure. I agree to testing for the determination of HIV infection. If I am found to have HIV, I agree to additional testing that may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time.

I also authorize release of this information to the health care professional, named above, who is treating the health care worker that has been exposed to my blood or body fluid.

Signature: _____
(Test subject or legally authorized representative)

Printed Name: _____

Date: _____

Patient ID#: _____

DOB: _____

Address: _____

_____

If legal representative, indicate relationship to subject:

_____

New York State Department of Health
AIDS Institute

Authorization for Release of Health Information and Confidential HIV-Related Information*

This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; or by special court order. Under New York State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of health and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By checking the boxes below and signing this form, health information and/or HIV-related information can be given to the people listed on page two (and on additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your health information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- ☐ My HIV-related information
- ☐ My non-HIV health information
- ☐ Both (non-HIV health and HIV-related information)

Name and address of facility/person disclosing HIV-related information:

_____

_____

Name of person whose information will be released: _____

Name and address of person signing this form (if other than above):

_____

_____

Relationship to person whose information will be released: _____

_____

Describe information to be released: _____

Reason for release of information: _____

Time Period During Which Release of Information is Authorized: From: _____ To: _____

Exceptions to the right to revoke consent, if any:

_____

_____

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits
(Note: Federal privacy regulations may restrict some consequences):

_____

_____

Please sign below **only** if you wish to authorize all facilities/persons listed on pages 1,2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services.

Signature _____ Date _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

Authorization for Release of Health Information and Confidential HIV-Related Information*

Complete information for each facility/person to be given general information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general health and/or HIV-related information:

_____

_____

Reason for release, if other than stated on page 1:

_____

_____

If information to be disclosed to this facility/person is limited, please specify:

_____

_____

Name and address of facility/person to be given general health and/or HIV-related information:

_____

_____

Reason for release, if other than stated on page 1:

_____

_____

If information to be disclosed to this facility/person is limited, please specify:

_____

_____

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York City Commission on Human Rights at (212) 306-7500 or the NYS Division of Human Rights at 1-888-392-3644.

My questions about this form have been answered. I know that I do not have to allow release of my health and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release health and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____ Date _____
(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

If legal representative, indicate relationship to subject:

Print Name _____

Client/Patient Number _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

Authorization for Release of Health Information and Confidential HIV-Related Information*

Complete information for each facility/person to be given general information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

If any/all of this page is completed, please sign below:

Signature _____ Date _____
(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

Client/Patient Number _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ (INSERT START DATE) until _____ (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.

	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ (SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW) _____ (DATE)

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ (STAFF PERSON'S NAME AND TITLE) _____ (SIGNATURE) _____ (DATE)

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

DOH-5032 (4/11)

NOTICE PROHIBITING REDISCLOSURE OF CONFIDENTIAL INFORMATION

This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure. Disclosure of confidential HIV information that occurs as the result of a general authorization for the release of medical or other information will be in violation of state law and may result in a fine or jail sentence or both.

(Source: Public Health Law § 2782(5); 10 N.Y.C.R.R. § 63.5)

LEGAL ACTION CENTER

Prepared by the Legal Action Center

LEGAL RESOURCES FOR PEOPLE WITH HIV-RELATED PROBLEMS

African Services Committee
429 W. 127th St
New York, NY 10027
(212) 222-3882

AIDS Center of Queens County (ACQC)
161 Jamaica Avenue
Jamaica, NY 11432
(718) 896-2500

Albany Law School, Health Law Clinic
80 New Scotland Avenue
Albany, NY 12208
(518) 445-2328 Ext. 3369

Bronx AIDS Services, Inc.
540 East Fordham Road
Bronx, NY 10458
(718) 295-5605

953 Southern Blvd.
Bronx, NY 10459
(718) 295-5690

Empire Justice Center
One West Main Street, Ste. 200
Rochester, NY 14614
(585) 454-4060
Note that Empire Justice Center provides legal services in Rochester, Geneva, Elmira, and Bath.

Erie County Bar Association
Volunteer Lawyers Project
237 Main Street # 1000
Buffalo, NY 14203
(716) 847-0662

Gay Men's Health Crisis
446 W. 33rd Street
New York, NY 10001
(212) 367-1000

HIV Law Project
15 Maiden Lane (18th Floor)
New York, NY 10038
(212) 577-3001

Legal Services of the Hudson Valley
90 Maple Avenue
White Plains, NY 10601
(877) 574-8529

30 S. Broadway
Yonkers, NY 10701
(914) 376-3751

Legal Action Center
225 Varick Street, 4th Floor
New York, NY 10014
(212) 243-1313

Legal Aid Society
Brooklyn Neighborhood Office
111 Livingston Street, 7th floor
Brooklyn, NY 11201
(718) 625-1803

Community Law Office
230 East 106th Street
New York, NY 10029
(212) 426-3000

Legal Services of Central New York
472 South Salina Street, 3rd Floor
Syracuse, NY 13202
(315) 703-6500

Manhattan Legal Services
1 W. 125th Street, 2nd Floor
New York, NY 10027
(646) 442-3100

Project Hospitality, Inc.
Legal Services Office
14 Slosson Terrace
Staten Island, NY 10301
(718) 720-8172

South Brooklyn Legal Services
105 Court Street, 3rd Floor
Brooklyn, NY 11201
(718) 237-5500

The Family Center
315 West 36th Street, 4th Floor
New York, NY 10018
(212) 766-4522

The Legal Action Center is the only non-profit law and policy organization in the United States whose sole mission is to fight discrimination against people with histories of addiction, HIV/AIDS, or criminal records, and to advocate for sound public policies in these areas.

Since 1973, LAC has worked to combat the stigma and prejudice that keep these individuals out of the mainstream of society. The Legal Action Center is committed to helping people reclaim their lives, maintain their dignity, and participate fully in society as productive, responsible citizens.

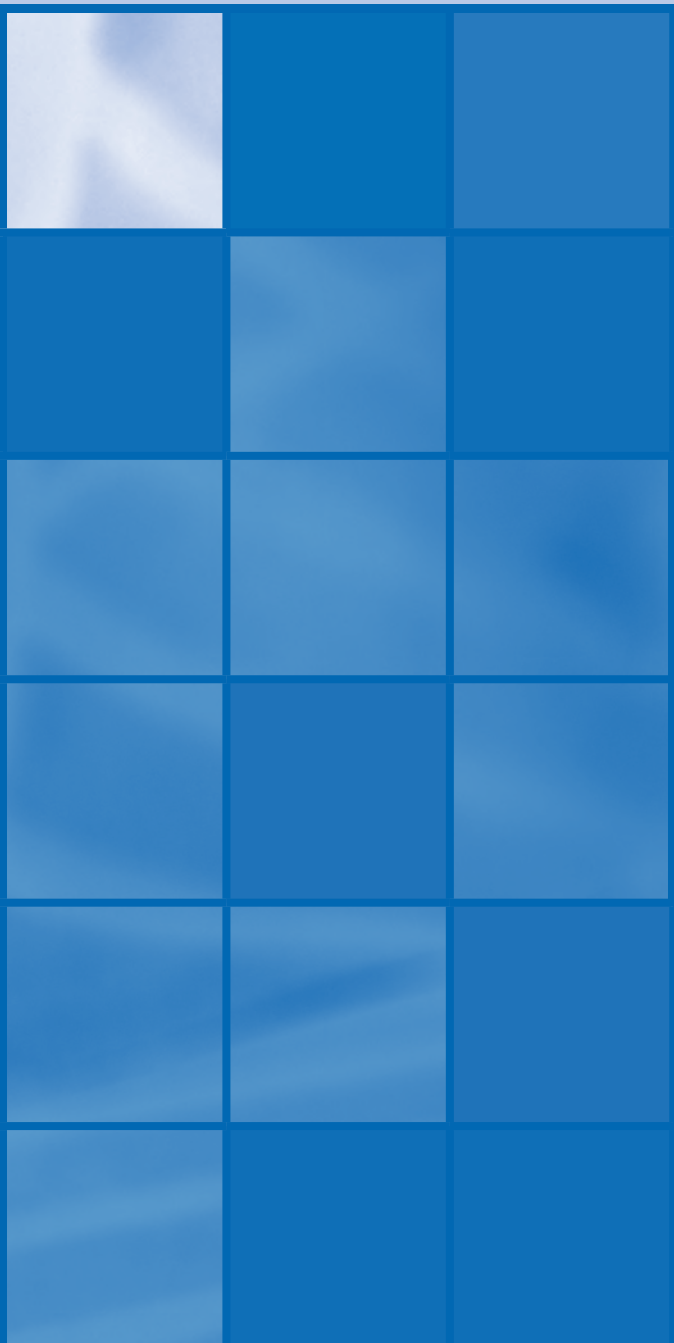
LEGAL ACTION CENTER

225 Varick Street New York, NY 10014
(212) 243-1313
www.lac.org

MEDICAID

A PRIMER

2010



THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

MEDICAID
A PRIMER

Key Information on Our Nation's Health Coverage Program for Low-Income People

June 2010

THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

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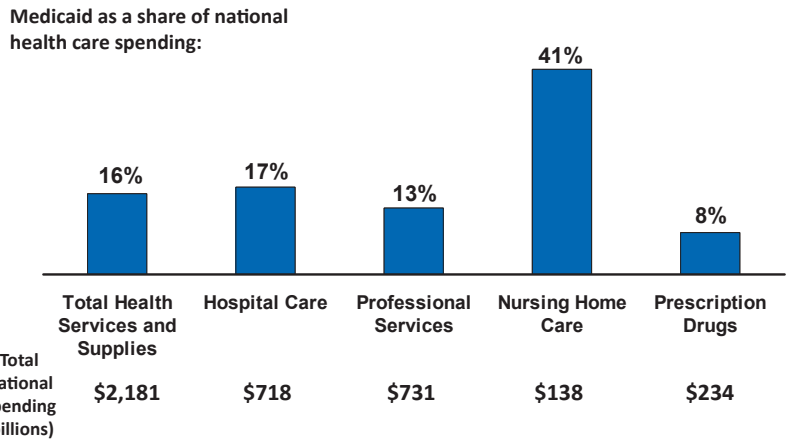
INTRODUCTION

No major health program or issue can be considered today outside the context of the nation's new health care reform law, known as the "Affordable Care Act."* The health reform law, the most significant social legislation in the U.S. since 1965, seeks to eliminate large and growing gaps in health insurance by increasing access to affordable coverage and instituting a new legal obligation on the part of individuals to obtain it. To accomplish this reform, the law creates a national framework for near-universal coverage and also outlines a comprehensive set of strategies to improve care and contain costs. Integral to the coverage framework laid out in the reform law is a dramatic expansion of the Medicaid program; half the expected gains in coverage due to health reform will be achieved through this expansion.

Figure 1

Medicaid in the Health System, 2008



Note: Does not include spending on CHIP.
SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, *National Health Expenditure Accounts*, January 2010.

The reliance on Medicaid as a platform for wider coverage of the low-income uninsured has a long history. Established in 1965 as part of President Johnson's "Great Society," Medicaid was originally conceived as a health coverage supplement only for those receiving cash welfare assistance. Overtime, Congress has expanded Medicaid substantially to fill growing coverage gaps left by the private insurance system. Many states have expanded eligibility for the program further and Medicaid has been the cornerstone of all state-level initiatives to broaden coverage of the uninsured. In 2007, Medicaid covered health and long-term care services for nearly 60 million people, including more than 1 in 4 children and many of the sickest and poorest in our nation. During the economic recession, Medicaid has provided a safety-net of coverage for millions more Americans affected by loss of work or declining income. Medicaid now provides benefits to more people than any other public or private insurance program, including Medicare.

* Health reform was enacted in two separate pieces of legislation. President Obama signed the Patient Protection and Affordable Care Act (P.L. 111-148) into law on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), signed on March 30, 2010, includes changes to new law.

As a mainstay of coverage in the U.S., Medicaid is also a core source of health care financing – it funds almost a sixth of total national spending on personal health care (Figure 1). Medicaid is the main payer of nursing home care and long-term care services overall; it is also the largest source of public funding for mental health care. Health centers and safety-net hospitals that serve low-income and uninsured people rely heavily on Medicaid revenues. Medicaid is an engine in state and local economies, too, supporting millions of jobs.

Looking ahead to the even larger role Medicaid will soon play under health care reform, understanding the program and how it fits into our health care system takes on additional importance. The purpose of this primer is to provide that foundation by explaining the basics of Medicaid and providing key information about the program today.

WHAT IS MEDICAID?

Medicaid is a public health insurance program that fills important gaps in our system today – gaps in coverage, long-term care, and financing for the safety-net delivery system. Under health reform, Medicaid's role in health coverage and financing will increase substantially. A significant expansion of Medicaid, which will extend health coverage to millions more low-income people, is the foundation of the national coverage system established by the new law. The federal government will finance the lion's share of the cost of the new coverage. States will continue to shape their own programs, but Medicaid eligibility will be simplified to support coordination between Medicaid and subsidized coverage offered in the new insurance exchanges.

What is Medicaid?

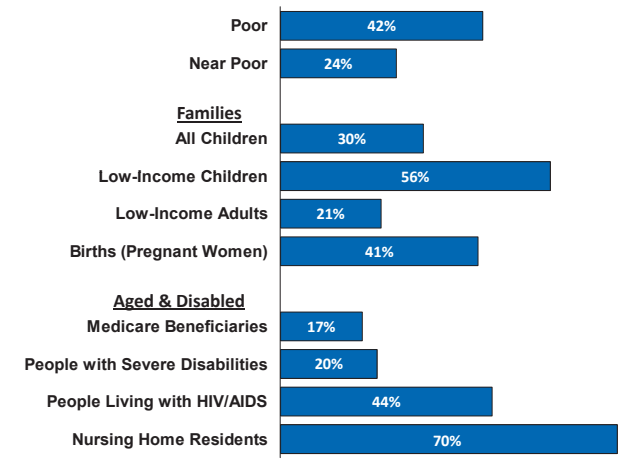
Medicaid is the nation's publicly financed health and long-term care coverage program for low-income people. Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is an entitlement program that was initially established to provide medical assistance to individuals and families receiving cash assistance, or "welfare." Over the years, Congress has incrementally expanded Medicaid eligibility to reach more Americans living below or near poverty, regardless of their welfare eligibility. Today, Medicaid covers a broad low-income population, including parents and children in both working and jobless families, individuals with diverse physical and mental conditions and disabilities, and seniors. Medicaid's beneficiaries include many of the poorest and sickest people in the nation.

What is Medicaid's role in the U.S. health care system?

Medicaid fills large gaps in our health insurance system. Medicaid provides health coverage for millions of low-income children and families who lack access to the private health insurance system that covers most Americans. The program also provides coverage for millions of people with chronic illnesses or disabilities who are excluded from private insurance or for whom such insurance, which is designed for a generally healthy population, is inadequate. Finally, Medicaid provides extra help for millions of low-income Medicare enrollees known as "dual eligibles," assisting them with Medicare premiums and cost-sharing and covering key services, especially long-term care, that Medicare limits or excludes. Medicaid is the nation's largest source of coverage for long-term care, covering more than two-thirds of all nursing home residents. (Figure 2)

Figure 2

Medicaid's Role for Selected Populations



SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of 2009 ASEC Supplement to the CPS; Birth data from *Maternal and Child Health Update: States Increase Eligibility for Children's Health in 2007*, National Governors Association, 2008; Medicare data from USDHHS.

By design, Medicaid expands to cover more people during economic downturns. Because eligibility for Medicaid is tied to having low income, and enrollment cannot be limited or waiting lists kept, the program operates as a safety-net. During economic recessions like the current one, when job loss causes workers and their families to lose health coverage and income, more people become eligible for Medicaid and the program expands to cover many of them, offsetting losses of private health insurance and mitigating increases in the number of uninsured.

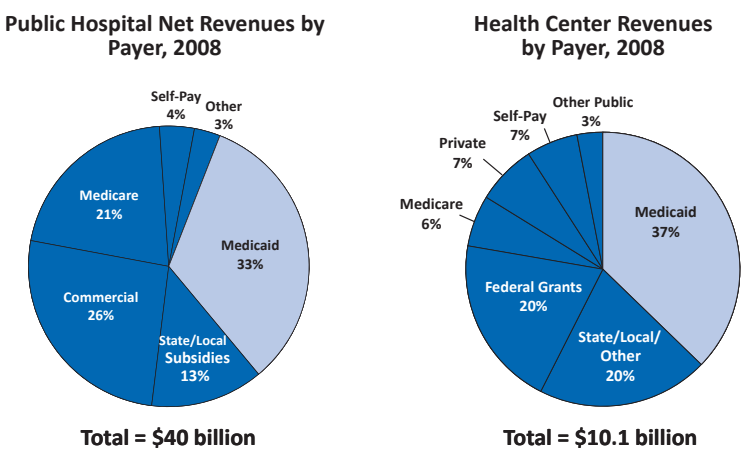
It is estimated that for every one percentage point increase in the unemployment rate, Medicaid enrollment grows by 1 million.[1] Medicaid enrollment growth has been accelerating in each six-month period since the recession began in December 2007. The largest six-month Medicaid enrollment increase on record occurred from December 2008 to June 2009, when 2.1 million additional individuals obtained Medicaid coverage. Between June 2008 and June 2009, enrollment rose by nearly 3.3 million, or 7.5%.

Medicaid is the main source of long-term care coverage and financing in the U.S. Over 10 million Americans, including about 6 million elderly and 4 million children and working-age adults, need long-term services and supports.[2] Medicaid covers about 7 of every 10 nursing home residents and finances over 40% of nursing home spending and long-term care spending overall.[3] More than half of all Medicaid long-term care spending is for institutional care, but a growing share – 41% in 2006, up from 30% in 2000 and 13% in 1990 – is attributable to home and community-based services.[4]

Medicaid funding supports the safety-net institutions that provide health care to low-income and uninsured people (Figure 3)**.** Medicaid provides 33% of public hospitals' net revenues. Medicaid payments provide an even larger share of health centers' total operating revenues (37%) and is their largest source of third-party payment.[5]

Figure 3

Medicaid Financing of Safety-Net Providers



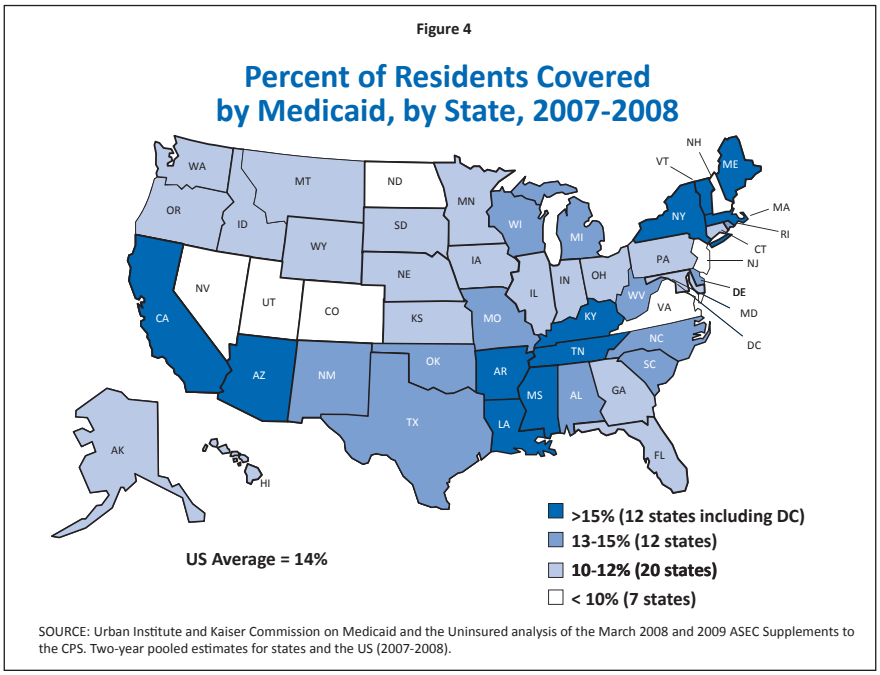
SOURCE : Data for public hospitals from *America's Public Hospitals and Health Systems, 2008*, National Association of Public Hospitals and Health Systems, February 2010. Health center data from 2008 Uniform Data System (UDS), Health Resources and Services Administration.

How is Medicaid structured?

Medicaid is financed jointly by the federal government and the states. The federal government matches state spending on Medicaid. States are entitled to these federal matching dollars and there is no cap on funding. This financing model supports the federal entitlement to coverage and allows federal funds to flow to states based on actual need. Through the matching arrangement, the federal government and the states share the cost of the program.

The states administer Medicaid within broad federal guidelines and state programs vary widely. State agencies administer Medicaid subject to oversight by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services (HHS). State participation in Medicaid is voluntary but all states participate. Federal law outlines basic minimum requirements that all state Medicaid programs must meet. However, states have broad authority to define eligibility, benefits, provider payment, delivery systems, and other aspects of their programs. As a result, Medicaid operates as more than 50 distinct programs – one in each state, the District of Columbia, and each of the Territories. Due to wide programmatic variation and demographic differences across the country, the proportion of the population covered by Medicaid varies from state to state, ranging from 8% in New Hampshire and Nevada to 22% in the District of Columbia (Figure 4).

Figure 4



SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of the March 2008 and 2009 ASEC Supplements to the CPS. Two-year pooled estimates for states and the US (2007-2008).

***States can seek federal waivers to operate their Medicaid programs outside of federal guidelines*.** Section 1115 of the Social Security Act gives the HHS Secretary authority to waive statutory and regulatory provisions of health and welfare programs, including Medicaid, for demonstration purposes. States can apply for Section 1115 waivers to operate their Medicaid programs outside regular federal rules. Some states have used waivers to expand Medicaid eligibility and to adopt new models of coverage and health care delivery for the low-income population.

***Medicaid's structure enables the program to adapt and evolve*.** The combination of the federal entitlement to Medicaid for all individuals who qualify, broad state flexibility in program design, and guaranteed federal matching funds has enabled Medicaid to respond to economic and demographic changes, and to address emergent needs – for example, by expanding during economic downturns and providing a coverage safety-net for many affected by the HIV/AIDS pandemic. In addition, as a major source of health care financing, Medicaid has leveraged improvements in health care, including new approaches to care coordination and management, as well as wider adoption of community-based alternatives to institutional long-term care.

WHO IS COVERED BY MEDICAID?

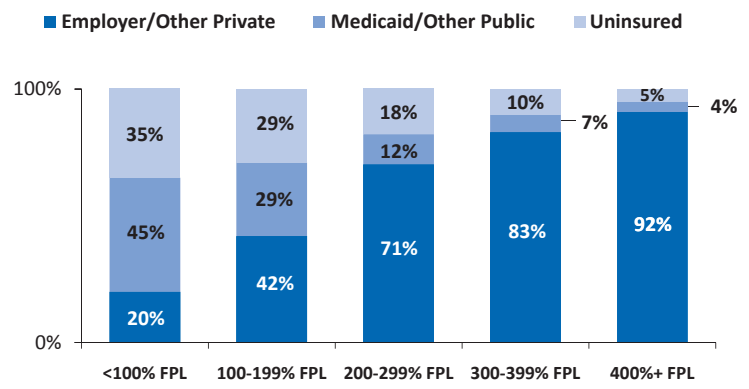
By design, Medicaid covers low-income and high-need populations. Medicaid plays an especially large role in covering children and pregnant women. It also covers millions of low-income Medicare beneficiaries and individuals with disabilities and chronic conditions. Currently, nearly all low-income children can qualify for Medicaid or the Children's Health Insurance Program. But Medicaid eligibility for low-income parents is far more limited and varies widely by state, and federal law categorically excludes adults without dependent children. Under health reform, "who is covered" will change dramatically. The new law simplifies and broadens Medicaid eligibility for the under-65 population by eliminating categorical criteria and establishing a national income eligibility floor at 133% of the poverty level. These reforms of Medicaid eligibility fit Medicaid into the national health coverage framework structured by the new law, establishing the program as the coverage pathway for low-income people.

What is Medicaid's coverage role?

Medicaid covers 45% of all poor Americans – those with income below the federal poverty level (FPL), which was $22,025 for a family of four in 2008* (Figure 5). Medicaid also covers more than one-quarter of near-poor Americans, those between 100% and 200% FPL. Most of the low-income individuals Medicaid covers are in working families but lack access to job-based health insurance or cannot afford the premiums. Most cannot obtain individual (non-group) health insurance either, because they cannot afford it or because they are excluded based on their health status or conditions. Overall, Medicaid beneficiaries are much poorer and in markedly worse health than low-income people with private insurance.

Figure 5

Health Insurance Coverage by Poverty Level, 2008



Note: The federal poverty level (FPL) was $22,025 for a family of four in 2008. Data may not total 100% due to rounding.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of 2009 ASEC Supplement to the CPS.

*$22,025 for a family of four is the 2008 poverty threshold published by the U.S. Census Bureau. Depending on the context, this *Primer* also sometimes uses the poverty guidelines issued by the U.S. Department of Health and Human Services.

Who can qualify for Medicaid?

Under current law, to qualify for Medicaid, a person must meet financial criteria and also belong to one of the groups that are "categorically" eligible for the program. Federal law requires states to cover certain "mandatory" groups in order to receive any federal matching funds. The mandatory groups are pregnant women and children under age 6 with family income below 133% FPL; children age 6 to 18 below 100% FPL; parents below states' July 1996 welfare eligibility levels (often below 50% FPL); and most elderly and persons with disabilities who receive Supplemental Security Income (SSI), a program for which income eligibility equates to 75% FPL for an individual. States have broad flexibility to determine their own methods for counting income and they may also impose an asset test. Nearly all state Medicaid programs have eliminated the asset test for children, but about half require an asset test for parents; almost every state applies an asset test in determining Medicaid eligibility for the elderly and people with disabilities.

Under the new health reform law, nearly everyone under age 65 – regardless of category – with income below a national "floor" will be eligible for Medicaid, making Medicaid the coverage pathway for many more low-income Americans. Historically, non-elderly adults without dependent children, no matter how poor they are, have been categorically excluded from Medicaid by federal law unless they are disabled or pregnant. States have been able to receive federal Medicaid funds to cover these adults only if they obtained a federal waiver; alternatively, states could use state-only dollars. The new health reform law ends the categorical exclusion of these adults as of 2014, expanding Medicaid eligibility nationally to reach adults under age 65 (both parents and those without dependent children) up to 133% FPL; an enhanced federal match rate applies for adults newly eligible for Medicaid as a result. Health reform did not change Medicaid eligibility for the elderly and people with disabilities.

States have the option to cover or phase-in coverage of the new eligibility group beginning April 1, 2010, rather than waiting until 2014. States (including those that have been covering childless adults in Medicaid with state-only dollars) can receive federal Medicaid matching funds for people in the new eligibility group. States' regular federal match rate applies for this group until 2014, when the enhanced federal match rate takes effect.

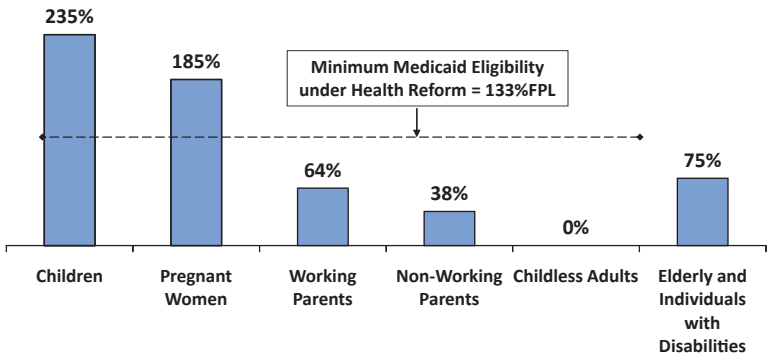
Medicaid eligibility is limited to American citizens and certain lawfully residing immigrants. Only American citizens and specific categories of lawfully residing immigrants can qualify for Medicaid. The Personal Responsibility and Work Opportunity Reconciliation Act, enacted in 1996, barred most lawfully residing immigrants from Medicaid during their first five years in the U.S., except for emergency treatment.[6] Some states have used state-only funds to cover these legal immigrants during the five-year ban. Recently, Congress gave states the option to receive federal Medicaid matching funds for lawfully residing immigrant children and pregnant women during their first five years in the U.S.[7] At this writing, 18 states including the District of Columbia had adopted the option to cover immigrant children, pregnant women, or both, without the five-year wait. The health reform law does not change any of the rules regarding immigrants' eligibility for Medicaid.

Documentation of citizenship and identity is required. Since July 1, 2006, most U.S. citizens applying for Medicaid coverage for the first time must, under federal law, document their citizenship and identity by submitting a passport or a combination of a birth certificate and an identity document.[8] (Previously, many states accepted applicants' self-declaration of citizenship under penalty of perjury.) Nearly all elderly individuals and people with disabilities are exempt from the citizenship documentation requirement, as are newborns whose deliveries were paid for by Medicaid. As of January 1, 2010, states have the option to satisfy the documentation requirement by conducting a data match with the Social Security Administration's database, using social security numbers, to verify U.S. citizenship. Almost half the states are now using or testing this data-match option.

States have broad discretion to expand Medicaid eligibility beyond federal minimum standards to cover additional "optional" groups. Optional eligibility groups include, among others: pregnant women, children, and parents with income exceeding the mandatory thresholds; elderly and disabled individuals up to 100% FPL; working disabled individuals up to 250% FPL; persons residing in nursing facilities with income below 300% of the SSI standard; individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services waivers; and the "medically needy," individuals who cannot meet the financial criteria but have high health expenses relative to their income, and who belong to one of the categorically eligible groups. Between Medicaid expansions for children and coverage under the Children's Health Insurance Program (CHIP), most states cover all children below 200% FPL. States have also expanded Medicaid to adult optional groups, but much less extensively, and Medicaid adult eligibility above federal minimum levels varies widely from state to state. (Figure 6)

Figure 6

Median Medicaid/CHIP Income Eligibility Thresholds, 2009



Note: Medicaid income eligibility for most elderly and individuals with disabilities is based on the income threshold of Supplemental Security Income (SSI).
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for Kaiser Commission on Medicaid and the Uninsured, 2009.

Individuals who qualify for Medicaid have a federal entitlement to coverage. Medicaid is an entitlement program. That means that any person who meets his or her state's Medicaid eligibility criteria has a federal right to Medicaid coverage in that state; the state cannot limit enrollment in the program or establish a waiting list. The guarantee of coverage and the obligation of states and the federal government to finance it distinguish Medicaid from the Children's Health Insurance Program (CHIP) and other block grant programs, which can limit enrollment.

Who is covered currently?

Over 46 million low-income children and parents, the majority of them in working families, rely on Medicaid. Medicaid is the largest source of health insurance for American children. In 2007, about 29 million children – over one-quarter of all children and more than half of low-income children – were enrolled in the program at some point during the year.[9] CHIP builds on Medicaid, covering more than 7 million children in families whose incomes are too high to qualify for Medicaid.[10] Medicaid covers close to 15 million low-income, non-elderly adults, primarily parents in working families. Most children and families covered by Medicaid would be uninsured without it as they lack access to private insurance.

Medicaid covers 8.8 million non-elderly people with disabilities, including 4 million children. Medicaid provides health and long-term care coverage for people with diverse physical and mental disabilities and chronic illnesses. Often, these individuals cannot obtain coverage in the private market or the coverage available to them falls short of their health care needs. Medicaid enables people with disabilities to gain access to a fuller range of the services they need, helping to maximize their independence and, in the case of some disabled adults, supporting their participation in the workforce. Medicaid covers a large majority of all poor children with disabilities.

Medicaid is a key source of coverage for pregnant women. Most states have expanded coverage of pregnant women beyond the federal minimum income eligibility level of 133% FPL. Sixteen states cover pregnant women up to 185% FPL and another 24 states provide eligibility at higher income levels. Medicaid improves access to prenatal care and neonatal intensive care for low-income pregnant women and their babies, helping to improve maternal health and reduce infant mortality, low-weight births, and avoidable birth defects. Medicaid funds approximately four of every ten births in the U.S. and is the largest source of public funding for family planning.[11]

Medicaid provides assistance for more than 8 million low-income Medicare beneficiaries**.** The federal *Medicare* program provides health insurance 47 million Americans, including 39 million seniors and 8 million non-elderly individuals with permanent disabilities. About 1 in 6 Medicare beneficiaries, based on their low income, are also covered by Medicaid and are known as "dual eligibles." Dual eligibles are much poorer and in worse health compared with other Medicare enrollees. Medicaid assists dual eligibles with Medicare premiums and cost-sharing and covers important services that Medicare limits or does not cover, especially long-term care. In 2005, dual eligibles accounted for 18% of Medicaid enrollees but 46% of all Medicaid spending for services. Until a prescription drug benefit was added to Medicare in 2006, Medicaid covered prescription drugs for dual eligibles and paid nearly 40% of their total health care costs.

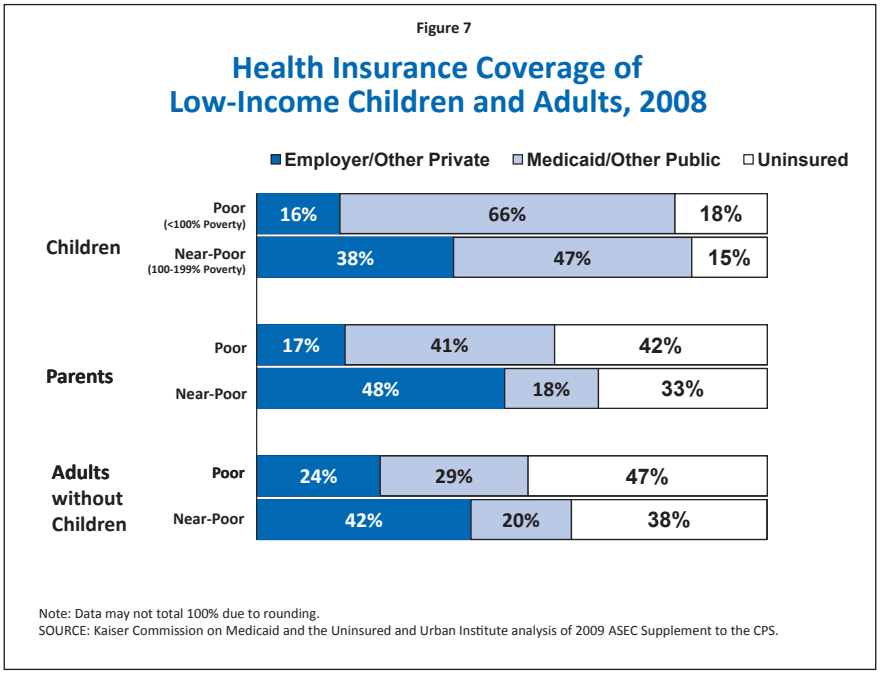
Medicaid is viewed favorably both by the general public and by those with experience in the program. A large majority of Americans view Medicaid as a very important program and would be willing to enroll in the program if they needed health care and qualified. Over half of adults have received Medicaid benefits themselves or have a friend or family member who has benefited from Medicaid.[12] Findings from surveys and focus group studies show a high degree of satisfaction with Medicaid among families with program experience.[13] They value both the breadth of Medicaid's benefits and the affordability of the coverage.

Who is left out of Medicaid?

Not all low-income Americans can currently qualify for Medicaid. Although Medicaid covers millions of poor and near-poor Americans, income and categorical restrictions currently exclude millions of low-income people – mostly adults. Due to these restrictions, which the new health reform law redresses, low-income adults today are much more likely than low-income children to be uninsured, as outlined more fully below.

Parents. While all poor children are eligible for Medicaid, many of their parents are not because most states have much stricter income eligibility for parents than for children. As of December 2009, 34 states set income eligibility for working parents at a level below 100% FPL, and half of those states set their levels below 50% FPL. In 29 states, a parent in a family of three working full-time at the state's minimum wage could not qualify for Medicaid.[14] Because their eligibility for Medicaid is so much more limited than children's, parents who are below or near the poverty level are more than twice as likely to be uninsured as children in the same income stratum (Figure 7). Health reform extends Medicaid eligibility, nationally, to nearly everyone under age 65 with income up to 133% FPL, closing the coverage gap that many low-income parents currently face.

Figure 7



Note: Data may not total 100% due to rounding.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of 2009 ASEC Supplement to the CPS.

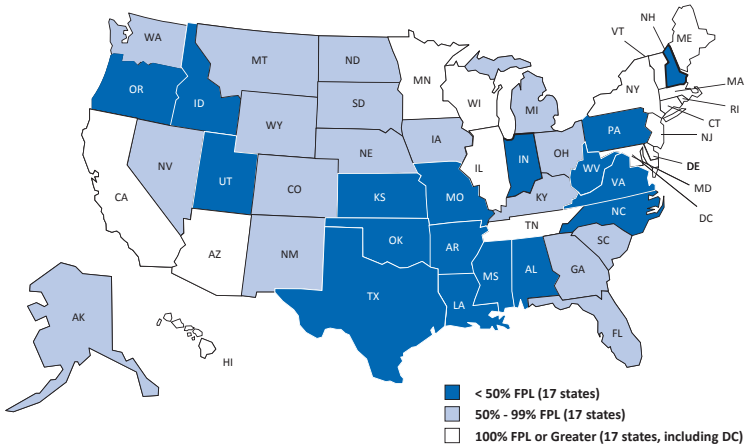
Adults without dependent children. Until health reform was enacted, federal law categorically excluded most adults without dependent children from Medicaid. States were precluded from receiving federal Medicaid matching funds for such adults – no matter how poor – unless they were pregnant or severely disabled. About half the states have federal waivers and/or use state-only funds to provide some kind of coverage to childless adults. Only five of these states provide Medicaid or Medicaid-like benefits; most provide more limited benefits or cover childless adults through workplace coverage under certain conditions.[15] In 2008, over 40% of low-income adults without children were uninsured, and these adults accounted for more than one-third of the 46 million non-elderly Americans who lacked insurance.[16] The national Medicaid expansion under health reform does away with the exclusion of childless adults and covers those with income up to 133%FPL. As mentioned previously, states have the option to implement this expansion immediately, rather than waiting until 2014 when the expansion is required.

Immigrants. In most states, lawfully residing immigrants are ineligible for Medicaid for their first five years in the U.S. While states can opt to cover legal immigrant pregnant women and children without a wait, most have not, and other legal immigrants remain barred from Medicaid for their first five years here. Federal law prohibits undocumented immigrants from enrolling in Medicaid. Medicaid payments may be made for undocumented immigrants only for emergency services and only if they would otherwise qualify for Medicaid. These rules do not change under health reform.

State-to-state variation in eligibility leads to marked inequities in low-income adults' access to Medicaid coverage. Because of state variation in Medicaid income eligibility levels and other state policy choices, adults at a given income level – even below the poverty level – may be eligible for Medicaid in one state but ineligible in another. In 2009, eligibility thresholds for working parents ranged from 17% FPL in Arkansas to 215% FPL in Minnesota (Figure 8). Twenty-five states including the District of Columbia had federal waivers or used state-only funds to provide Medicaid coverage to childless adults.[17] Due to federal minimum standards, Medicaid income eligibility levels for pregnant women and children are somewhat uniform, but other low-income adults' access to Medicaid coverage varies widely across the states.

Figure 8

Medicaid Eligibility for Working Parents by Income, December 2009



Note: The federal poverty line (FPL) for a family of three in 2009 was $18,310 per year.
SOURCE: Based on a national survey conducted by Kaiser Commission on Medicaid and the Uninsured with the Center on Budget and Policy Priorities, 2009.

Can Medicaid cover more of the uninsured?

Many people who are eligible for Medicaid are not enrolled. Participation in Medicaid is high compared with other voluntary programs. Yet many who could gain coverage under the program are not enrolled. Over 70% of uninsured children are potentially eligible for Medicaid or CHIP but not enrolled. Some low-income families are not aware of the programs or do not believe their children qualify. In addition, although important improvements have been made over the last decade, mostly for children, burdensome enrollment and renewal requirements still pose major obstacles to participation. Responding to evidence that citizenship documentation requirements have imposed a further burden on U.S. citizens who are eligible for Medicaid and impeded their participation, Congress enacted changes to ease the impact.[18]

States that meet performance goals related to enrolling Medicaid-eligible children can qualify for federal bonus payments. The Children's Health Insurance Program Reauthorization Act (CHIPRA), enacted in February 2009, provided for federal performance bonuses to be paid to states that both implement an array of policies to encourage enrollment and retention of children in Medicaid and CHIP and achieve child enrollment in Medicaid that exceeds targets specified in the law. The more children a state enrolls above the target, the larger the federal bonus payment to the state. The intent of the bonuses is to promote and reward increased enrollment of children who are eligible for Medicaid but uninsured. In December 2009, HHS awarded nine states $72.6 million in performance bonuses.

"Churning" in Medicaid interrupts coverage and care and contributes to the number of Americans without insurance. Documentation and other administrative requirements cause many eligible children and families to lose their Medicaid coverage at renewal time. This "churning" – people cycling on and off the program – disrupts coverage and care and leads to uninsured spells. Many states, when fiscally strong, have stepped up their Medicaid outreach, simplified enrollment and renewal, and taken other actions to promote participation. However, when faced with difficult budget pressures, states have often reduced their efforts or even reinstated barriers that dampen participation in an attempt to control costs.

For health reform to achieve its coverage goals, effective Medicaid outreach and easy enrollment and renewal procedures will be needed. The potential of health reform to cover millions of low-income, uninsured individuals and families is contingent on improving participation in Medicaid. Particular efforts will be needed to reach childless adults, who are new to Medicaid, to introduce the program to them and motivate them to participate. Research shows that easy procedures for enrolling in and renewing Medicaid coverage are also necessary to convert eligibility to participation.

WHAT SERVICES DOES MEDICAID COVER?

Medicaid covers a broad array of health and long-term care services, including many services not typically covered by private insurance. Cost-sharing is tightly restricted to minimize financial barriers to access for the low-income people Medicaid serves. The benefit package for children is comprehensive. Federal law gives states more latitude in defining the benefit package for adults. Under health reform, individuals newly eligible for Medicaid generally will receive "benchmark" or "benchmark-equivalent" benefits, which must include at least the "essential health benefits" required of coverage in the new exchanges. The health reform law offers financial incentives to states to increase access to preventive care in Medicaid and to provide "health home" services to better coordinate care for people with chronic conditions. The law also increases states' opportunities to expand access to home and community-based long-term services and gives states financial incentives to further shift their Medicaid long-term services to non-institutional settings. A new Medicaid and CHIP Payment and Access Commission (MACPAC) is charged with assessing a broad set of access issues.

What does the Medicaid benefit package include?

Because Medicaid enrollees have diverse and often extensive needs, Medicaid benefits include a broad range of health and long-term care services. Medicaid covers parents and children, pregnant women, people with physical and mental disabilities and chronic diseases of all kinds, and seniors. To address the wide-ranging health needs of its diverse enrollees and their limited ability to afford care out-of-pocket, Medicaid benefits include the health services typically covered by private insurance, but also many additional services, such as dental and vision care, transportation and translation services, and long-term care services and supports. Some covered benefits, such as services provided by federally qualified health centers, reflect the special role that certain institutions and other providers play in furnishing care to the low-income population. States use numerous tools to manage utilization, such as prior authorization and case management.

State Medicaid programs must cover "mandatory services" specified in federal law in order to receive any federal matching funds. Most Medicaid beneficiaries are entitled to receive the mandatory services listed below. Medicaid services are covered subject to medical necessity, as determined by the state Medicaid program or a managed care plan that is under contract to the state.

- Physicians' services
- Hospital services (inpatient and outpatient)
- Laboratory and x-ray services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21
- Federally-qualified health center and rural health clinic services
- Family planning services and supplies
- Pediatric and family nurse practitioner services
- Nurse midwife services
- Nursing facility services for individuals 21 and older
- Home health care for persons eligible for nursing facility services
- Transportation services

States are also permitted to cover many important services that federal law designates as "optional." Many of these optional services are particularly vital for persons with chronic conditions or disabilities and the elderly. Prescription drugs (which all states cover), personal care services, and rehabilitation services are just three examples. The inclusion of many of these services in state Medicaid programs despite their "optional" designation in federal statute is evidence that, as a practical matter, they are often considered essential. Nonetheless, when states are under severe budget strains, such as in the current economic recession, "optional" benefits like dental services for adults are particularly vulnerable to cuts. Close to one-third of Medicaid spending is estimated to be attributable to optional services.[19]

Commonly offered optional services include:

- Prescription drugs
- Clinic services
- Care furnished by other licensed practitioners
- Dental services and dentures
- Prosthetic devices, eyeglasses, and durable medical equipment
- Rehabilitation and other therapies
- Case management
- Nursing facility services for individuals under age 21
- Intermediate care facility for individuals with mental retardation (ICF/MR) services
- Home- and community-based services (by waiver)
- Inpatient psychiatric services for individuals under age 21
- Respiratory care services for ventilator-dependent individuals
- Personal care services
- Hospice services

How are Medicaid benefits different from typical private health benefits?

The pediatric Medicaid benefit, known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), encompasses a comprehensive array of health services for children. EPSDT is a mandatory benefit that entitles Medicaid enrollees under age 21 to all services authorized by federal Medicaid law, including services considered optional for other populations and often not covered by private insurance. In addition to screening, preventive, and early intervention services, EPSDT covers diagnostic services and treatment necessary to correct *or ameliorate* children's acute and chronic physical and mental health conditions. Services that are particularly important for children with disabilities, such as physical therapy, personal care services, and durable medical equipment, which are often limited or excluded under private insurance, are covered as needed under EPSDT.

The concept of medical necessity in EPSDT is expansive, consistent with an emphasis in Medicaid on promoting children's healthy development and maximizing their health and function. Further, the limits that states may impose on services for adults cannot be applied to children. In principle at least, EPSDT represents a uniform and comprehensive federal benefit package for low-income children.

In addition to acute health services, Medicaid covers a wide range of long-term services and supports that Medicare and most private insurance exclude or narrowly limit. Medicaid long-term care services include comprehensive services provided in nursing homes and intermediate care facilities for the mentally retarded (ICF-MR), as well as a wide range of services and supports needed by people, young and old, to live independently in the community – home health care, personal care, medical equipment, rehabilitative therapy, adult day care, case management, respite for caregivers, and other services. Because Medicare and private insurers provide little coverage of long-term care, Medicaid is by far the largest source of assistance for these costly services. Driven partly by the Supreme Court's *Olmstead* decision concerning the civil rights of people with disabilities in public programs, both federal and state Medicaid policy have increasingly supported home and community-based alternatives to institutional long-term care.

Health care reform creates new opportunities and incentives for states to balance their Medicaid long-term care delivery systems by expanding access to home and community-based services. The new law expands states' current Medicaid options to provide home and community-based benefits, both enlarging the scope of services covered and broadening financial and functional eligibility criteria to expand access to these benefits. The law also provides increased financial incentives for states that further shift their Medicaid long-term services to non-institutional settings.

Separate from Medicaid, the health reform law establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS). The program will be financed through payroll deductions; all working-age adults will be enrolled automatically unless they opt out. Subject to a five-year vesting period, CLASS will provide cash benefits to individuals with functional limitations for non-medical services and supports necessary to maintain community residence.

The broad array of services Medicaid covers is particularly important for the care of low-income people with chronic illnesses and disabilities, who include pre-term babies, individuals with mental illness, people living with HIV/AIDS, and many with Alzheimer's disease. Another distinctive purpose of Medicaid's is to provide access to care for people with disabilities and complex conditions, who often have extensive needs for both acute care and long-term services. Medicaid's coverage of services needed especially by such individuals, such as case management, dental care, mental and behavioral health services, rehabilitation services, personal care, and nursing facility and home health care, is a defining aspect of the program. Millions of Americans with diverse disabilities and needs depend on Medicaid. Medicaid is the single largest public payer of mental health care in our system.[20] It is also the nation's largest source of coverage for people with HIV, covering about 40% of those estimated to be receiving care for disease.[21]

How do states define their Medicaid benefit packages?

In general, states must provide the same Medicaid benefit package to all categorically eligible individuals in their state. Generally, federal Medicaid law requires states to cover the same benefits for all categorically eligible individuals (whether mandatory or optional) statewide, and the services must be comparable, regardless of individuals' diagnoses or conditions. States have flexibility to define the amount, duration, and scope of the Medicaid services they cover, but federal law requires that coverage of each mandatory and optional service be "sufficient in amount, duration, and scope to reasonably achieve its purpose."

States can offer more limited "benchmark" benefits to some groups. In the Deficit Reduction Act of 2005, Congress changed the law to permit states to provide some groups with more limited benefits modeled on specified "benchmark" plans, and to offer different benefits to different enrollees.[22] States providing benchmark or benchmark-equivalent coverage must provide EPSDT "wraparound" coverage for children. Most groups are exempt from benchmark coverage, including mandatory pregnant women and parents, individuals with severe disabilities, individuals who are medically frail or have special needs, dual eligibles, people with long-term care needs, and specified other groups. Few states have used the new authority. Four states have provided different tiers of benefit packages for different groups, two of them limiting or granting access to certain benefits based on enrollees' health behaviors.[*] Four other states have used the authority to enhance Medicaid coverage for specified populations.

Medicaid benefits vary considerably across the states. Medicaid benefit packages vary widely from state to state. States cover different optional services. They also define amount, duration, and scope differently. Except with regard to children, states can place limits on covered services – for example, by capping the number of physician visits or prescription drugs that are allowed. Finally, while federal law includes a "medically necessary" standard to ensure appropriate use of Medicaid services, states define and apply the medical necessity standard somewhat differently.

States can impose premiums and cost-sharing in Medicaid subject to some federal limitations. In 2005, Congress loosened longstanding rules that sharply restricted states' use of premiums and cost-sharing in Medicaid. Premiums remain prohibited for most children and adults below 150% FPL. However, for most children and adults with income above 150% FPL, premiums as well as cost-sharing up to 20% of the cost of the service are now permitted.

For most services, cost-sharing is largely prohibited for mandatory children and it is limited to nominal levels for adults below 100% FPL. For other children and adults up to 150% FPL, cost-sharing is limited to 10% of the cost of the service. Total cost-sharing and premiums cannot exceed 5% of family income for any family, and cost-sharing for preventive care is prohibited for children at all income levels. Finally, the 2005 rules also give states the option to terminate Medicaid coverage if premiums are not paid and, except for mandatory children and adults under 100%FPL, to grant health care providers the right to deny care if Medicaid patients do not pay their cost-sharing charges.[23]

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[*] Recent federal regulations further delineate the scope of state flexibility regarding benchmark packages. To comply with these rules, one of the states that restricted benefits (WV) has discontinued doing so; other states may also have to reexamine their benchmark policies in light of the new rules.

Under health reform, adults newly eligible for Medicaid will receive a benchmark benefit package, or broader benefits if a state elects. Beginning January 1, 2014, newly-eligible Medicaid adults, unless they belong to one of the exempt groups mentioned above, will receive benchmark or benchmark-equivalent coverage. The reform law establishes a new minimum standard for benchmark benefits, requiring that they include at least the "essential health benefits" required of health plans in the new insurance exchanges. These benchmark benefits may be more limited than states' current Medicaid benefits, but states retain the flexibility to provide more comprehensive or full Medicaid benefits to new eligibles.

How do Medicaid enrollees receive services?

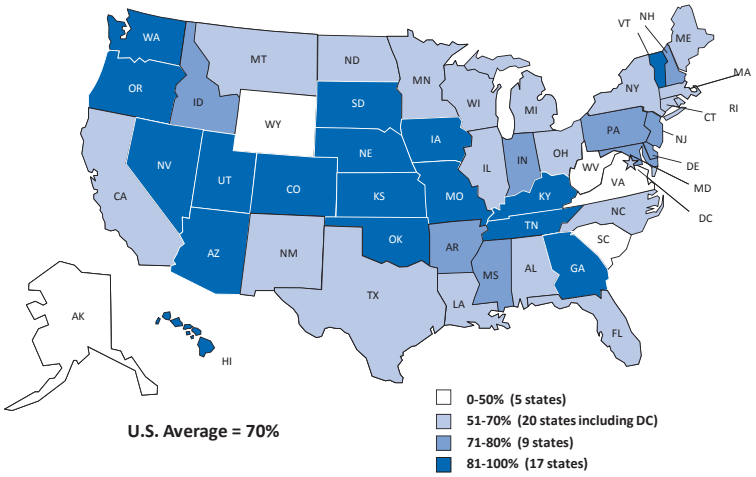
Although Medicaid is publicly financed, the program purchases health services primarily in the private sector. Medicaid is a publicly financed health coverage program, but it is not a government-run care delivery system. On the contrary, the Medicaid program generally procures services for its beneficiaries in the private health care market. States pay health care providers for services furnished to their Medicaid beneficiaries. Medicaid programs purchase services on a fee-for-service basis, or by paying premiums to managed care plans under contracts, or by using a combination of both approaches.

Managed care is the most common health care delivery system in Medicaid. In 2008, about 70% of Medicaid enrollees received some or all of their services through managed care arrangements (Figure 9). The two main models of managed care in Medicaid are managed care organizations (MCO) and primary care case management (PCCM). MCOs are paid on a capitation basis and assume the financial risk for comprehensive Medicaid services or a defined set of services (e.g., ambulatory care, dental services). In PCCM, the primary care provider receives a small fee per person per month to provide basic care and coordinate specialist care and other needed services, which are usually paid fee-for-service.

Healthy children and families make up the lion's share of Medicaid managed care enrollees, but many states are now enrolling more complex populations, including children and adults with disabilities and chronic illnesses and dual eligibles, in managed care arrangements. Several states are applying managed care principles to long-term care; new initiatives include projects that integrate acute and long-term care within MCO delivery systems.[24]

Figure 9

Medicaid Managed Care Penetration Rates by State, 2008



Note: Unduplicated count. Includes managed care enrollees receiving comprehensive and limited benefits.
SOURCE: Medicaid Managed Care Enrollment as of December 31, 2008. Centers for Medicare and Medicaid Services.

States are using a variety of approaches to balance their long-term care delivery systems in favor of community settings. As the demand for long-term services in the community is growing, efforts to make Medicaid benefits more flexible and allow consumer involvement in determining and managing services are expanding across the states. Many states allow some form of consumer direction of personal assistance services, giving the Medicaid beneficiary more control over hiring, scheduling, and paying personal care attendants. Under health reform, states have increased opportunities to expand access to home and community-based services, and the law extends an existing demonstration program that provides states with enhanced federal matching funds for each Medicaid beneficiary they transition from an institution to the community.

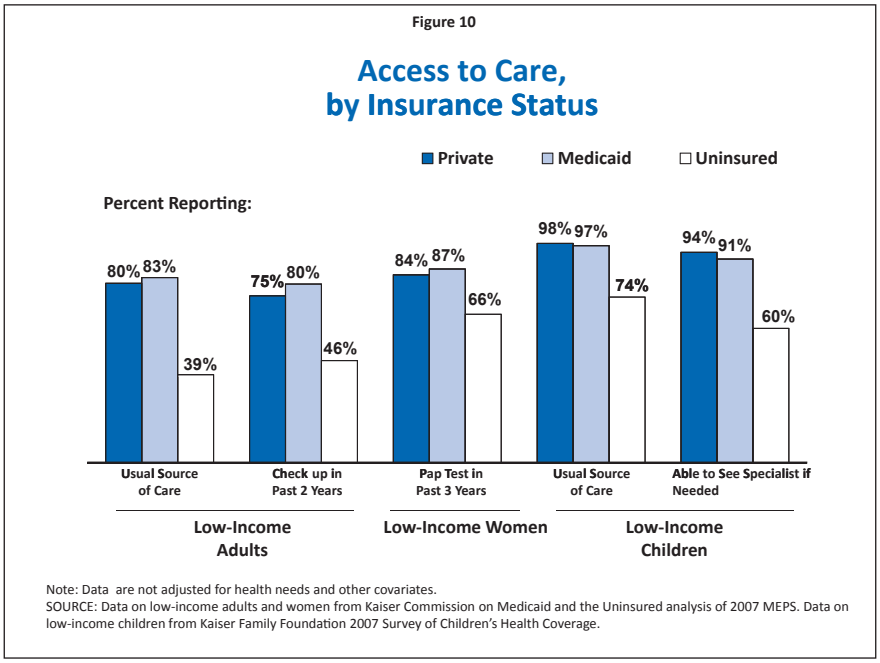
States have built delivery systems designed to serve the Medicaid population. Whether they use managed care, fee-for-service, or a combination of strategies, many states have developed strong care delivery networks that rely heavily on community health centers and other safety-net providers located in the communities where low-income people reside. These providers are often uniquely prepared and competent to address diverse low-income populations' needs for services and supports.

New models of care are emerging in Medicaid. Many states are building into their PCCM programs features to enhance the coordination and management of care for enrollees with chronic illnesses and disabilities. Some disease and care management programs are targeted to people with specific conditions, and others target individuals with multiple conditions. A number of states are structuring payment strategies and incentives to support the "patient-centered medical home" model for Medicaid beneficiaries. This model emphasizes continuous and comprehensive care, care teams directed by a personal physician, and care for all stages of life. It also seeks to enhance access through expanded hours and other improvements. Information technology and quality improvement activities promote quality and safety.

How is access to care in Medicaid?

Medicaid increases access to care and limits out-of-pocket burdens for low-income people. Children and adults enrolled in Medicaid have much better access to care than the uninsured, and pregnant women covered by Medicaid obtain more timely and adequate prenatal care than their low-income, uninsured counterparts.[25] [26] On key measures of access to preventive and primary care, Medicaid enrollees fare as well as people with private health insurance (Figure 10).[27] [28] [29] In addition, Medicaid's strict limits on cost-sharing help to ensure that, for the low-income and high-need population the program serves, cost is not an obstacle to obtaining care.[30] Research shows that Medicaid beneficiaries are substantially less likely to face high financial burdens for health care than low-income people with private insurance.[31]

Figure 10

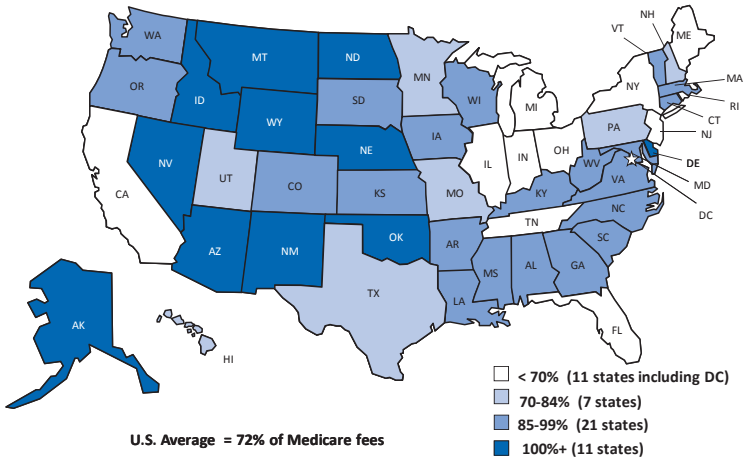


Note: Data are not adjusted for health needs and other covariates.
SOURCE: Data on low-income adults and women from Kaiser Commission on Medicaid and the Uninsured analysis of 2007 MEPS. Data on low-income children from Kaiser Family Foundation 2007 Survey of Children's Health Coverage.

System-wide problems with access to care are amplified in Medicaid. Shortages and inadequacies in the distribution of certain providers and specialists have contributed to access problems in the private and public sectors alike, but low provider payment and participation rates compound these problems in Medicaid (Figure 11). Gaps in access to specialist and dental care in Medicaid are a major concern. In provider surveys and other research, low provider payment and administrative burden consistently emerge as leading barriers to provider acceptance of Medicaid.[32] Also, providers often do not locate in low-income neighborhoods, creating time, distance, and cost barriers to access for people living in these communities.

Figure 11

Medicaid-To-Medicare Provider Fee Ratios for All Services



Note: Tennessee does not have a fee-for-service component in its Medicaid program
SOURCE: Zuckerman, Williams, and Stockley, "Trends in Medicaid Physician Fees, 2003-2008," *Health Affairs*, April 28, 2009.

Provider participation and systems of care affect access. A number of states have achieved gains in provider participation in Medicaid following increases in provider payment and increased provider outreach and support.[33] MCOs have the potential to structure and deliver a network of providers to Medicaid beneficiaries who, on their own in a fee-for-service environment, might have difficulty identifying providers willing to serve them. At the same time, access in managed care arrangements depends on provider networks that are adequate to meet the needs of Medicaid enrollees and mechanisms that connect enrollees with timely and appropriate care.

To help boost access to primary care in Medicaid, the health reform law requires states to pay the Medicare payment rate for primary care services furnished by primary care physicians in 2013 and 2014 and provides full federal funding for this increase. The law also funded the recently-established Medicaid and CHIP Payment and Access Commission (MACPAC), which is charged with monitoring access in the two programs, identifying gaps, and making recommendations concerning payment and access issues.

How does Medicaid monitor and promote quality?

States use a variety of data and payment strategies to improve quality in Medicaid. Increasingly, states are using standardized data to benchmark and improve the quality of care provided by managed care programs and other medical providers. Most states require MCOs serving Medicaid enrollees to provide data on specified utilization and performance measures (from the Healthcare Effectiveness Data and Information Set (HEDIS)), and most also use the patient satisfaction surveys (Consumer Assessment of Healthcare Providers and Systems (CAHPS)) in MCOs as a quality gauge; a smaller number of states do so in PCCM and fee-for-service. More and more states are publicly reporting the quality data they collect, both to help beneficiaries choose plans based on quality considerations and to drive improvements in provider performance. A growing number of states require or reward MCOs that are accredited by a recognized standard-setting organization. Finally, pay-for-performance (P4P) systems in most states financially reward high performance by MCOs and/or physicians, hospitals, nursing homes, and other providers.[34]

States are using health information technology (HIT) in a variety of ways to improve quality and safety in Medicaid. Medicaid programs in most states are participating in electronic prescribing and electronic health record (EHR) or electronic medical record (EMR) initiatives to promote better coordination of care. Some states are using Medicaid claims data to design evidence-based recommendations for care; some are facilitating data-sharing among agencies and providers that care for children.[35] HHS is developing a core set of children's healthcare quality measures for children enrolled in Medicaid or CHIP that will be useful in state efforts to evaluate the "meaningful use" of HIT, a criterion for qualifying for new HIT payment incentives to providers (described below).

Substantial new federal investments are likely to foster increased HIT initiatives in Medicaid. ARRA provided $21.6 billion in Medicaid funding to encourage physicians, hospitals, and other health care providers to adopt and "meaningfully use" certified EHRs. Illustrations of meaningful use include use for electronic prescribing, electronic exchange of health information to improve quality of care, and reporting on clinical quality measures. Full federal funding is initially available for Medicaid incentive payments to eligible providers to help offset the costs of purchasing, implementing, operating, maintaining, and using the technology, training, and other costs. Generally, to qualify for incentive payments, providers must serve a minimum level of Medicaid and other low-income patients. ARRA also provides 90% federal funding for states to administer the EHR incentives, including actions to encourage adoption of EHR and track meaningful use. The HIT investments are estimated to generate $12 billion in savings attributable to improved quality, care coordination, and reductions in medical errors and duplicative care. Complementing the funds for HIT incentive payments are two competitive grant programs for states, one to enable states to make loans to providers for technology purchasing and training, and another for states to facilitate and expand electronic exchange of health information among organizations.[36]

HOW MUCH DOES MEDICAID COST?

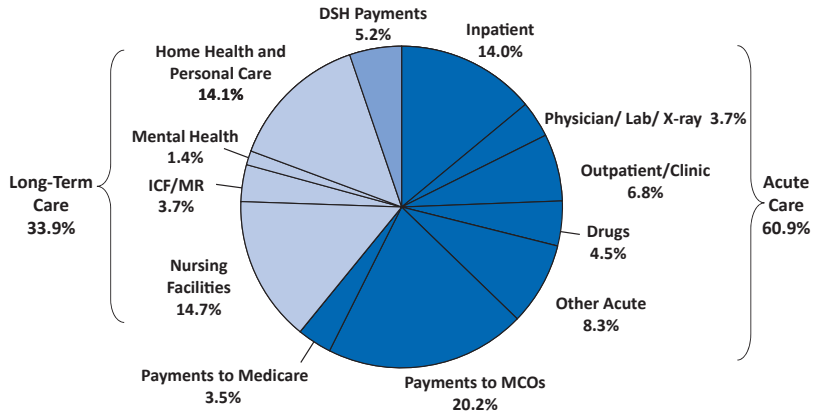
In 2008, Medicaid spending totaled about $339 billion. Spending is distributed across a broad array of health and long-term care services. Medicaid spending is high because of the extensive health needs of many of its beneficiaries. The top 5% percent of spenders in Medicaid account for nearly 60% of total spending. Also, close to half of Medicaid spending is attributable to low-income Medicare beneficiaries who also qualify for Medicaid. Total Medicaid spending will rise under health reform as millions of people become eligible for the program. The Congressional Budget Office projects that the expansion will cost states $20 billion over the next decade, an increase of 1.25 percent over what they would otherwise have spent; the federal government will finance 96% of the cost of the coverage expansion over the ten years.

What does Medicaid cost currently?

In 2008, total federal and state Medicaid spending on services was nearly $339 billion (Figure 12*)*. Over 60% of spending was attributable to acute care, including payments to managed care plans. More than a third (34%) of spending went toward long-term care. Medicaid administrative costs were 5% (not shown).

Figure 12

Medicaid Expenditures by Service, 2008



Total = $338.8 billion

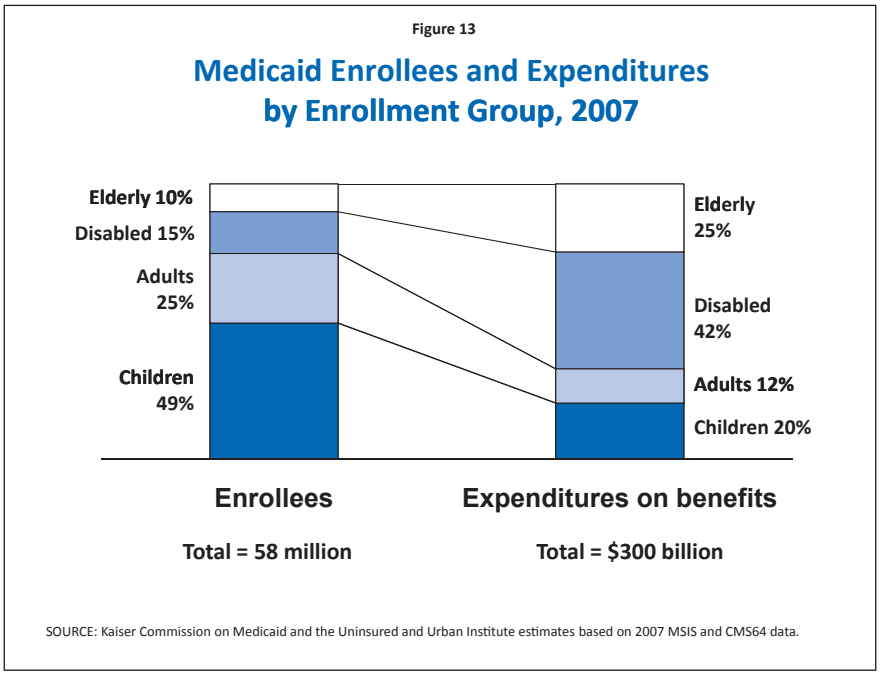
NOTE: Total may not add to 100% due to rounding. Excludes administrative spending, adjustments and payments to the territories.
SOURCE: Urban Institute estimates based on data from CMS (Form 64), prepared for the Kaiser Commission on Medicaid and the Uninsured.

Medicaid makes special payments to hospitals that serve a disproportionate share of low-income and uninsured patients. About 5% of Medicaid spending is attributable to supplemental payments to hospitals that serve a disproportionate share of low-income and uninsured patients, known as "DSH." DSH payments help to support the safety-net hospitals that provide substantial uncompensated care.

What drives Medicaid spending?

Children and their parents make up the majority of Medicaid enrollees, but most Medicaid spending is attributable to the elderly and people with disabilities. Children, parents, and pregnant women make up three-quarters of the Medicaid population but account for only about a third (32%) of Medicaid spending. The elderly and disabled make up one-quarter of the Medicaid population but account for roughly two-thirds of spending. (Figure 13)

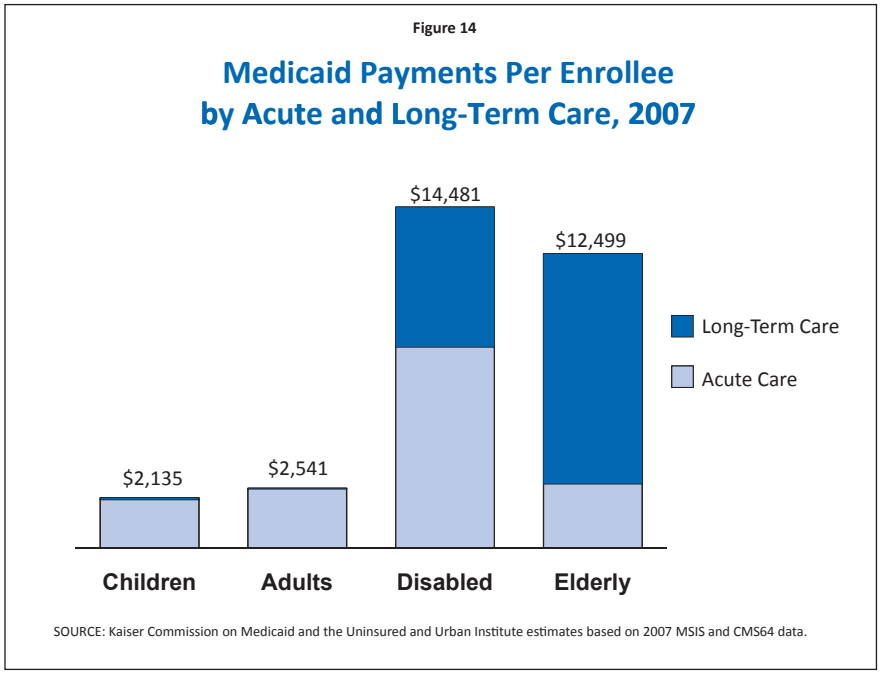
Figure 13



SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on 2007 MSIS and CMS64 data.

Medicaid spending per enrollee varies sharply by eligibility group. In 2007, the per capita cost for children covered by Medicaid was about $2,100, compared to $2,500 per adult, $14,500 per disabled enrollee and $12,500 per elderly enrollee (Figure 14). Higher per capita expenditures for disabled and elderly beneficiaries reflect their intensive use of both acute and long-term care services.

Figure 14



SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on 2007 MSIS and CMS64 data.

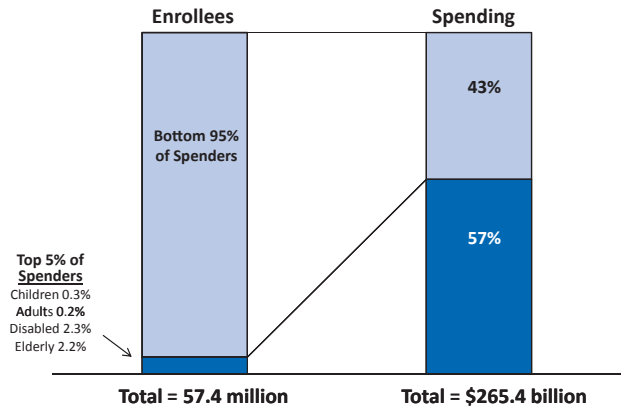
More than 45% of all Medicaid spending for medical services is attributable to dual eligibles. In 2005, dual eligibles – low-income individuals who are enrolled in both Medicare and Medicaid – made up 18% of the Medicaid population, but accounted for 46% of Medicaid spending. More than half of Medicaid spending for dual eligibles is for long-term care services. Until 2006, Medicaid provided prescription drug coverage for dual eligibles because Medicare did not include a drug benefit. Beginning January 2006, Medicare covers prescription drugs under the new Part D, but states make a monthly "clawback" payment to the federal government to help finance the benefit. The payments roughly reflect what states would have spent if they continued to pay for outpatient prescription drugs through Medicaid on behalf of their dual eligibles. In 2006, state clawback payments totaled $6.6 billion.

Desirable coordination between Medicare and Medicaid benefits and integration of acute and long-term care for dual eligibles has long been a policy goal. To support improved coordination of care for dual eligibles, as well as better-coordinated payment, the health reform law established a federal Coordinated Health Care Office within CMS.

The five percent of Medicaid beneficiaries with the highest costs account for over half of all Medicaid spending. Medicaid spending is highly skewed; a very small group of high-cost enrollees accounts for a large share of Medicaid spending. In 2004, the 1% of Medicaid enrollees with the highest health and long-term care costs accounted for one-quarter of Medicaid spending, and the highest-cost 5% of enrollees accounted for 57% of all program spending (Figure 15). This pattern, in which the high costs of a small share of enrollees drive total spending, holds in each of Medicaid's four major eligibility groups.

Figure 15

5% of Medicaid Enrollees Accounted for 57% of Medicaid Spending in 2004



SOURCE: Kaiser Commission in Medicaid and the Uninsured and Urban Institute estimates based on 2004 MSIS.

Under health reform, a new Center for Medicare and Medicaid Innovation is established within CMS. The Center is charged with testing, evaluating, and expanding innovative service delivery and payment models in Medicare, Medicaid, and CHIP to foster patient-centered care and improve quality while reducing spending.

Along with the health needs of the Medicaid population, growth in Medicaid enrollment and rising health care costs are major drivers of Medicaid costs. Between 2000 and 2007, Medicaid enrollment increased from 31.8 million to 42.3 million, or at an average annual rate of 4.2 percent.[37] Between June 2008 and June 2009, in the midst of the current recession, enrollment grew by 3.3 million, or 7.5%. Several factors fuel Medicaid enrollment. When state economies are strong, states seeking to broaden coverage may expand Medicaid eligibility. In economic recessions, job loss and resulting losses of job-based insurance and declining income cause more people to qualify for Medicaid. Ongoing erosion in employer-sponsored insurance contributes as well. Medicaid spending trends also reflect health care cost inflation, a systemic problem that drives health spending across our entire system.

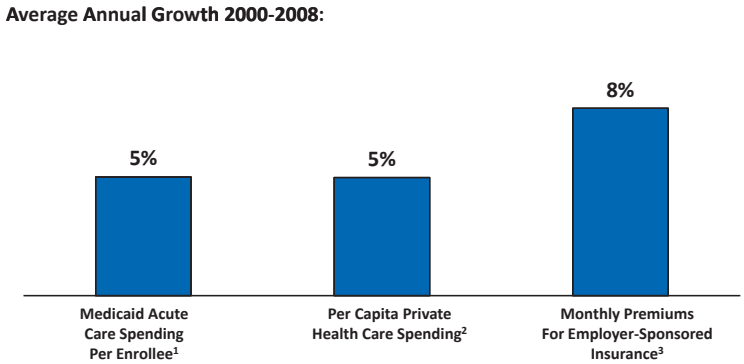
How effectively is Medicaid spending managed?

Medicaid is a low-cost program when the health needs of its beneficiaries are taken into account. Medicaid spending is high primarily because of the high-need people Medicaid serves. Medicaid enrollees overall are in significantly worse health than the low-income, privately insured population. When health status differences are controlled to make the Medicaid and low-income, privately insured populations more comparable, per capita spending for both adults and children is lower in Medicaid than under private insurance. Medicaid's lower spending levels are due mostly to its lower provider payment rates; differences in access to specialists and expensive technology for those in fair or poor health may also be a factor.[38]

Medicaid spending per capita has not risen faster than private health spending per capita. On a per capita basis, Medicaid acute care spending has been growing at the same rate as private health spending and less than monthly premiums for private insurance (Figure 16). From 2000 to 2008, the increase in acute care spending per Medicaid enrollee averaged 5% per year, as did growth in per capita private health care spending. Over the same period, monthly premiums for job-based coverage for an individual rose 8% per year on average.

Figure 16

Growth in Medicaid Acute Care Spending vs. Private Health Spending, 2000-2008



[1] Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of MSIS, CMS-64, and Kaiser Commission on Medicaid and the Uninsured/Health Management Associates data, 2010. 2005-07 data adjusted for shift to Medicare of dual eligibles' prescription drug spending. [2] National Health Expenditure Accounts, 2010. [3] *Kaiser/HRET Survey of Employer-Sponsored Health Benefits*, 2000-2008. Data reported are for single premiums. Family premium growth averaged 8.8% over the period.

Program management tools at the federal and state level help to ensure proper payment and improve Medicaid's efficiency. In 2006, Congress established a federal Medicaid Integrity Program (MIP) within CMS and provided substantial resources annually for audits, identification of fraud and abuse and other overpayments, education regarding program integrity and quality of care, and other purposes.[39] Most operational program integrity responsibilities rest with the states, but the MIP greatly enlarged the federal government's commitment to and CMS' accountability for sound and efficient management of the Medicaid program.

A separate mechanism for ensuring Medicaid (and CHIP) integrity is the Payment Error Rate Measurement Program (PERM). Under this initiative, a random sample of claims (both fee-for-service and managed care) and eligibility determinations are reviewed in a third of the states each year to determine error rates. Errors include payments that should not have been made or were made in the wrong amount, and also payments that were incorrectly denied. CMS calculates state and national error rates and reports to HHS and the Office of Management and Budget. States must submit a corrective plan to CMS and reimburse the federal government for its share of any overpayments.

HOW IS MEDICAID FINANCED?

Medicaid is financed through a federal-state partnership in which the federal government matches each state's spending based on a statutory formula. Under the normal formula, the federal government funds about 57% of all Medicaid spending, but with a temporary increase in the federal match rate to provide fiscal relief to states during the recession, the overall federal share is 66%. Under health care reform, the federal-state partnership in financing Medicaid will continue. However, the federal government will finance the full cost of the new coverage in the first three years of reform and the lion's share in subsequent years.

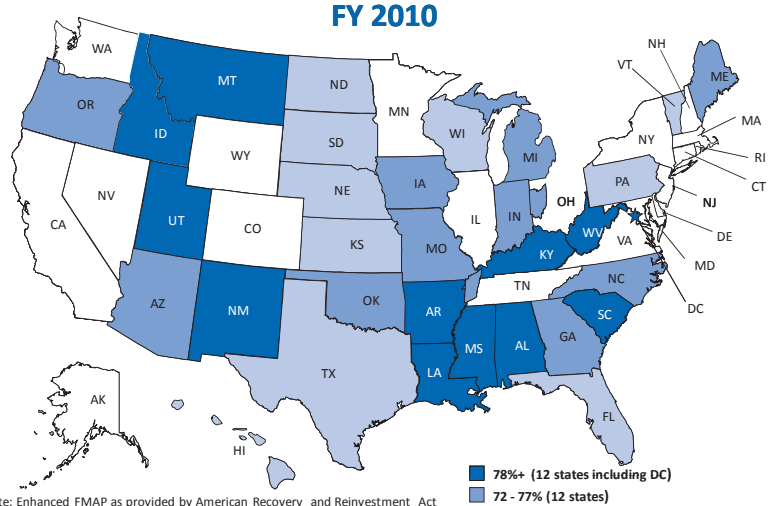
Who pays for Medicaid?

Medicaid is financed through a partnership between the federal government and the states. The federal government matches state spending on Medicaid. The federal match rate is known as the Federal Medical Assistance Percentage, or FMAP, and it varies based on state per capita income relative to the national average. The FMAP is at least 50% in every state. It is higher in relatively poor states, reaching 76% in the poorest state, Mississippi (Figure 17). The federal match rate for most Medicaid administrative costs is 50%. Federal matching dollars are guaranteed and flow to states based on need (as reflected by state spending), rather than on the basis of a pre-set formula or projected need. Overall, the federal government funds about 57% of Medicaid spending.

The American Recovery and Reinvestment Act (ARRA), enacted in February 2009 to boost the ailing economy, provided for a temporary increase in the FMAP. This federal relief supports the states in a period when they are facing rising Medicaid enrollment but are least able to afford it. With the ARRA adjustment, the FMAP for fiscal year 2010 ranges from 56% to 85%. The FMAP enhancement increases federal Medicaid spending by about $87 billion over the period October 1, 2008 through December 31, 2010, and increases the federal share of total Medicaid spending from 57% to 66%.[40] The enhanced FMAP rates will expire at the end of 2010, unless extended by Congress.

Figure 17

Enhanced Federal Medical Assistance Percentages (FMAP), FY 2010



Note: Enhanced FMAP as provided by American Recovery and Reinvestment Act of 2009 (ARRA). FMAPs are for 2nd quarter of 2010.
SOURCE: Kaiser Commission on Medicaid and the Uninsured calculations based on FY2010 FMAPs published in Federal Register, Vol. 75, No. 83.

Medicaid is a major source of federal revenue to the states. At the same time that Medicaid is a major spending program, it is also the largest source of federal revenue to the states. Federal Medicaid dollars are the single largest source of federal grant support to states, accounting for an estimated 44% of all federal grants to states in 2008.[41] Medicaid currently accounts for about 7% of federal budget outlays.[42]

States commit substantial funds to Medicaid. On average, states spend about 16% of their general funds on Medicaid, making it the second largest item in most states' general fund budgets, following spending for elementary and secondary education, which represented 35% of state general fund spending in 2008.[43] Medicaid spending pressures are a perennial issue at the state level. This is so because states have limited fiscal capacity to meet the many competing demands they face and must balance their budgets. State budget pressures intensify during economic downturns, when state revenues decline just as enrollment in Medicaid and other assistance programs is growing.

Medicaid is a major engine in state economies. Economic research shows that state Medicaid spending has a "multiplier effect" as the money injected into the state economy through the program generates successive rounds of earning and purchasing by businesses and residents. This economic activity supports jobs and yields additional income and state tax revenues. Compared with other state spending, Medicaid spending is especially beneficial because it also triggers an infusion of new federal dollars into the state economy, intensifying the multiplier effect.[44]

How well does Medicaid's financing structure support the program?

Medicaid's financing structure gives states flexibility to respond to changing and emerging needs and supports state efforts to expand coverage to the uninsured. When states spend their dollars on Medicaid, federal matching dollars follow. The matching system increases states' capacity to respond to changes in needs, economic conditions, and demographics, and to disasters and epidemics. Guaranteed federal matching payments provide an incentive to states to invest in health care and discourage them from reducing coverage. At the same time, states' incentives to control their costs constrain state Medicaid spending, and thus, federal Medicaid spending as well.

Federal matching rates are based on lagged data that may not reflect current economic conditions. The FMAP formula that determines the federal share of Medicaid spending in each state is based on the relationship between the state's per capita income and the national average. However, because the income data used in the FMAP formula are lagged, a state's match rate may reflect economic conditions that differ dramatically from current conditions. For example, in an economic downturn, some states may actually receive a reduced federal match because the data used in the FMAP calculation reflect a different set of economic circumstances.

The current financing system for Medicaid does not adequately account for the "countercyclical" nature of the program. By design, during economic downturns such as the current recession, when people lose their jobs and their health coverage and income decline, Medicaid expands. However, economic downturns also cause state tax revenues to shrink, reducing state capacity to afford increased enrollment just when it is most likely to occur. The current FMAP formula, which uses lagged data and is based solely on per capita income, does not provide an effective "countercyclical" adjustment to increase federal assistance to states during economic downturns. The temporary increase in the FMAP provided by ARRA was a legislative response to this problem. In effect, the FMAP increase *is* a countercyclical adjustment that boosts the federal share of Medicaid costs temporarily, while states are crunched between rising demands for Medicaid coverage and dwindling coffers due to the recession. As a condition of receiving the enhanced federal match, states cannot reduce Medicaid eligibility or use more restrictive rules for determining eligibility. Similar to relief provided in 2003 during the last economic decline, the ARRA FMAP increase has been instrumental in helping states to avoid additional and deeper reductions in their Medicaid programs, address budget shortfalls, and preserve coverage.

Under health reform, the federal government will finance the vast majority of the costs of new Medicaid coverage. The federal-state financing partnership that supports the current Medicaid program will continue under health reform. However, the cost of the new Medicaid coverage stemming from health reform will be fully financed by the federal government in the first three years of reform (2014-2016); in subsequent years, the federal government will continue to finance the lion's share, phasing down to 90% in 2020 and thereafter. Overall, federal funds will finance 96% of the cost of the Medicaid expansion over the first decade.

HOW DOES HEALTH REFORM RESHAPE MEDICAID FOR THE FUTURE?

The Affordable Care Act establishes a national framework for near-universal health coverage. Under the law, beginning in 2014, a new individual mandate will require most individuals to obtain coverage. At the same time, access to affordable health coverage will be improved through a significant expansion of the Medicaid program, the creation of new health insurance exchanges, and reforms of the private health insurance market. The major expansion of Medicaid and health reform's reliance on the program as the foundation for coverage of low-income people give Medicaid both a much larger and a distinctively national coverage role going forward.

- ***Medicaid eligibility reform.*** Under health reform, Medicaid eligibility for people under age 65 will be based solely on income. With categorical restrictions abolished for this population, Medicaid coverage will be extended to millions more low-income people, including both parents and adults without dependent children. In addition, a national Medicaid eligibility floor will apply, all states will count income using a specified, uniform method, and there will be no asset test. As a result of these provisions, nearly everyone under age 65 with income below 133% of the poverty level will qualify for Medicaid, significantly reducing uninsurance and state variation in coverage. These changes define Medicaid as the national coverage pathway for low-income individuals and families; they also introduce a degree of standardization in eligibility across state Medicaid programs to permit necessary coordination between Medicaid and the health insurance exchanges in the new national system.

- ***Simplified enrollment.*** The simplified, uniform methods for determining Medicaid eligibility help set the stage for simplified Medicaid enrollment procedures. Further, the new law requires that states streamline and coordinate their Medicaid and exchange enrollment systems in a "no wrong door" approach, to promote coverage, minimize the burden on people seeking coverage, and ensure their enrollment in the appropriate program. Additional requirements, investments, and incentives in the law push toward increased use of automation and technology in Medicaid to optimize participation and stable coverage.

- ***Improved access to care.*** The law includes an array of measures to increase physician participation and access to care in Medicaid, especially primary care. Full federal financing is provided to raise Medicaid payment rates for primary care to Medicare levels in 2013 and 2014. The law also gives states financial incentives to cover preventive care for adults in Medicaid. Other provisions seek to correct shortcomings in the healthcare workforce that hit underserved communities especially hard. The newly created Medicaid and CHIP Payment and Access Commission (MACPAC) is charged to assess access issues broadly. Innovation in service delivery is another focus of the law. For example, the law includes financial incentives for states to provide "health home" services to better coordinate care for Medicaid enrollees with chronic conditions, and new options to increase access to community-based long-term care. Also, a new federal office is established to coordinate care and financing for dual eligibles.

- ***Financing***. About 16 million more people are projected to gain Medicaid or CHIP coverage by 2019 due to the expansion of Medicaid eligibility and increased participation that is expected as the public responds to health reform. The Congressional Budget Office estimates that the federal government will finance about 96% of the coverage increases associated with reform between 2010 and 2019 ($434 billion), and states will contribute 4% ($20 billion).

As the nation prepares to implement health reform, understanding Medicaid is more important than ever. Key information about how the program operates and fits into our system today can help to ground policymakers and the interested public, orienting them to Medicaid's current scope and role, while providing perspective on how health reform reshapes the program for the future, preparing it for the central role it is to play in the national plan for covering our people.

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TABLES

Table 1

Medicaid Expenditures by Type of Service, FFY 2008

	Expenditures (in millions)						
	Total	Acute Care*		Long-Term Care*		DSH Payments	
State	$	$	%	$	%	$	%
United States	**$338,791**	**$206,256**	**61%**	**$114,797**	**34%**	**$17,739**	**5%**
Alabama	4,078	2,292	56%	1,358	33%	428	11%
Alaska	890	533	60%	342	38%	16	2%
Arizona**	7,506	5,594	75%	1,797	24%	115	2%
Arkansas	3,287	2,074	63%	1,167	36%	46	1%
California	38,748	24,125	62%	12,457	32%	2,166	6%
Colorado	3,169	1,832	58%	1,171	37%	166	5%
Connecticut	4,544	1,878	41%	2,384	52%	281	6%
Delaware	1,102	755	68%	342	31%	6	1%
District of Columbia	1,446	980	68%	396	27%	70	5%
Florida	14,691	10,054	68%	4,305	29%	331	2%
Georgia	7,338	5,056	69%	1,881	26%	401	5%
Hawaii	1,207	770	64%	406	34%	31	3%
Idaho	1,207	771	64%	414	34%	22	2%
Illinois	11,602	8,289	71%	3,119	27%	194	2%
Indiana	6,151	3,607	59%	1,966	32%	578	9%
Iowa	2,844	1,501	53%	1,293	45%	50	2%
Kansas	2,274	1,268	56%	926	41%	81	4%
Kentucky	4,809	3,246	68%	1,367	28%	196	4%
Louisiana	6,068	3,218	53%	1,885	31%	965	16%
Maine	2,253	1,451	64%	752	33%	50	2%
Maryland	5,701	3,585	63%	2,005	35%	111	2%
Massachusetts	10,822	7,670	71%	3,152	29%	0	0%
Michigan	9,847	7,042	72%	2,319	24%	486	5%
Minnesota	6,978	3,882	56%	2,956	42%	139	2%
Mississippi	3,812	2,401	63%	1,215	32%	195	5%
Missouri	7,090	4,620	65%	1,800	25%	670	9%
Montana	776	432	56%	329	42%	15	2%
Nebraska	1,588	861	54%	701	44%	27	2%
Nevada	1,317	836	63%	398	30%	83	6%
New Hampshire	1,257	495	39%	539	43%	223	18%
New Jersey	9,425	4,189	44%	3,709	39%	1,527	16%
New Mexico	3,045	2,245	74%	801	26%	-1	0%
New York	47,618	24,284	51%	20,324	43%	3,011	6%
North Carolina	10,162	6,680	66%	3,065	30%	417	4%
North Dakota	534	191	36%	342	64%	1	0%
Ohio	13,054	7,044	54%	5,371	41%	639	5%
Oklahoma	3,539	2,231	63%	1,257	36%	51	1%
Oregon	3,220	1,961	61%	1,187	37%	73	2%
Pennsylvania	16,300	8,916	55%	6,586	40%	798	5%
Rhode Island	1,834	1,025	56%	581	32%	228	12%
South Carolina	4,437	2,863	65%	1,132	26%	442	10%
South Dakota	656	382	58%	272	41%	1	0%
Tennessee	7,176	5,080	71%	1,930	27%	165	2%
Texas	21,461	14,827	69%	5,176	24%	1,459	7%
Utah	1,517	1,099	72%	398	26%	20	1%
Vermont	973	545	56%	392	40%	36	4%
Virginia	5,384	3,094	57%	2,117	39%	173	3%
Washington	6,293	3,894	62%	2,073	33%	326	5%
West Virginia	2,278	1,299	57%	906	40%	73	3%
Wisconsin	4,989	3,034	61%	1,800	36%	156	3%
Wyoming	493	257	52%	236	48%	0	0%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from CMS (Form 64).
Note: Does not include administrative costs, accounting adjustments, or the U.S. Territories. Total Medicaid spending including these additional items was $352.1 billion in FFY 2008. Figures may not sum to totals due to rounding.
* Acute care services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, family planning, dental, vision, other practitioners'' care, payments to managed care organizations, and payments to Medicare.
** Long-term care services include nursing facilities, intermediate care facilities for the mentally retarded, mental health, home health services, and personal care support services.
"DSH" refers to disproportionate share hospital payments.

Table 2

Federal Medical Assistance Percentages, FY 2006-2010

State	FY 2006	FY 2007	FY 2008	FY 2009*	FY 2010*	Federal Funds Sent to State for Each Dollar in State Medicaid Spending, FY 2010
Alabama	69.5%	68.9%	67.6%	77.5%	77.5%	$3.45
Alaska	57.6%	57.6%	52.5%	61.1%	62.5%	$1.66
Arizona	67.0%	66.5%	66.2%	75.9%	75.9%	$3.15
Arkansas	73.8%	73.4%	72.9%	80.5%	81.2%	$4.31
California	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
Colorado	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
Connecticut	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
Delaware	50.1%	50.0%	50.0%	61.6%	61.8%	$1.62
District of Columbia	70.0%	70.0%	70.0%	79.3%	79.3%	$3.83
Florida	58.9%	58.8%	56.8%	67.6%	67.6%	$2.09
Georgia	60.6%	62.0%	63.1%	74.4%	75.0%	$2.99
Hawaii	58.8%	57.6%	56.5%	67.4%	67.4%	$2.06
Idaho	69.9%	70.4%	69.9%	79.2%	79.2%	$3.80
Illinois	50.0%	50.0%	50.0%	61.9%	61.9%	$1.62
Indiana	63.0%	62.6%	62.7%	74.2%	75.7%	$3.11
Iowa	63.6%	62.0%	61.7%	70.7%	72.6%	$2.64
Kansas	60.4%	60.3%	59.4%	69.4%	69.7%	$2.30
Kentucky	69.3%	69.6%	69.8%	79.4%	80.1%	$4.04
Louisiana	69.8%	69.7%	72.5%	80.8%	81.5%	$4.40
Maine	62.9%	63.3%	63.3%	74.4%	74.9%	$2.98
Maryland	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
Massachusetts	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
Michigan	56.6%	56.4%	58.1%	70.7%	73.3%	$2.74
Minnesota	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
Mississippi	76.0%	75.9%	76.3%	84.2%	84.9%	$5.61
Missouri	61.9%	61.6%	62.4%	73.3%	74.4%	$2.91
Montana	70.5%	69.1%	68.5%	77.1%	78.0%	$3.54
Nebraska	59.7%	57.9%	58.0%	67.8%	68.8%	$2.20
Nevada	54.8%	53.9%	52.6%	63.9%	63.9%	$1.77
New Hampshire	50.0%	50.0%	50.0%	60.2%	61.6%	$1.60
New Jersey	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
New Mexico	71.2%	71.9%	71.0%	79.4%	80.5%	$4.13
New York	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
North Carolina	63.5%	64.5%	64.1%	74.5%	75.0%	$3.00
North Dakota	65.9%	64.7%	63.8%	70.0%	70.0%	$2.33
Ohio	59.9%	59.7%	60.8%	72.3%	73.5%	$2.77
Oklahoma	67.9%	68.1%	67.1%	75.8%	76.7%	$3.30
Oregon	61.6%	61.1%	60.9%	72.6%	72.9%	$2.69
Pennsylvania	55.1%	54.4%	54.1%	65.6%	65.9%	$1.93
Rhode Island	54.5%	52.4%	52.5%	63.9%	63.9%	$1.77
South Carolina	69.3%	69.5%	69.8%	79.4%	79.6%	$3.90
South Dakota	65.1%	62.9%	60.0%	70.6%	70.8%	$2.42
Tennessee	64.0%	63.7%	63.7%	74.2%	75.4%	$3.06
Texas	60.7%	60.8%	60.5%	69.9%	70.9%	$2.44
Utah	70.8%	70.1%	71.6%	80.0%	80.8%	$4.20
Vermont	58.5%	58.9%	59.0%	70.0%	70.0%	$2.33
Virginia	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
Washington	50.0%	50.1%	51.5%	62.9%	62.9%	$1.70
West Virginia	73.0%	72.8%	74.3%	83.1%	83.1%	$4.90
Wisconsin	57.7%	57.5%	57.6%	69.9%	70.6%	$2.40
Wyoming	54.2%	52.9%	50.0%	58.8%	61.6%	$1.60

Source: Kaiser Commission on Medicaid and the Uninsured calculations based on FFY 2006-2009 FMAPs as published in the Federal Register as follows:
FY 2006 FMAP Vol. 69, No. 226, pp. 68370-28373; FY 2007 FMAP Vol. 70, No. 229, pp. 71856-71857; FY 2008 FMAP Vol. 71, No. 230, pp. 69209-6921
FY 2009 FMAP Vol. 74, No. 234, pp. 64697-64700; FY 2010 FMAP Vol . 75, No. 83, pp. 22807-2280

Note: FY2006 and FY2007 for Alaska are from Federal Register, May 15, 2006 (Vol. 71, No. 93), pp. 28041-28042. FY 2009 and FY2010 FMAPs relfect additional federal Medicaid funding available through the American Recover and Reinvestment Act (ARRA) of 2009, P.L. 111-5.

* FY 2009 FMAPs are for the 4th Quarter of that fiscal year, and FY2010 FMAPs are for the 2nd Quarter of 2010.

Table 3

Medicaid Enrollment by Group, FFY 2007

	Enrollment (rounded to nearest 100)								
	Total	Aged		Disabled		Adult		Children	
State	Number	Number	%	Number	%	Number	%	Number	%
United States	**58,106,000**	**5,934,900**	**10%**	**8,789,500**	**15%**	**14,627,000**	**25%**	**28,754,500**	**49%**
Alabama	918,800	124,800	14%	194,500	21%	158,400	17%	441,100	48%
Alaska	120,800	8,500	7%	14,900	12%	24,500	20%	72,900	60%
Arizona	1,455,800	90,700	6%	137,900	9%	545,700	37%	681,400	47%
Arkansas	692,300	64,800	9%	120,200	17%	133,700	19%	373,700	54%
California	10,511,100	952,500	9%	964,300	9%	4,318,100	41%	4,276,200	41%
Colorado	553,800	48,300	9%	76,700	14%	98,900	18%	329,800	60%
Connecticut	530,300	65,700	12%	68,200	13%	116,900	22%	279,500	53%
Delaware	184,900	13,900	8%	22,300	12%	69,600	38%	79,100	43%
District of Columbia	164,900	14,600	9%	33,200	20%	40,200	24%	76,900	47%
Florida	2,842,400	399,500	14%	469,400	17%	514,100	18%	1,459,400	51%
Georgia	1,685,000	166,000	10%	258,400	15%	276,800	16%	983,800	58%
Hawaii	216,600	22,900	11%	25,100	12%	72,800	34%	95,800	44%
Idaho	212,500	16,200	8%	35,900	17%	28,600	13%	131,800	62%
Illinois	2,322,500	219,300	9%	292,700	13%	498,700	21%	1,311,800	56%
Indiana	1,022,700	82,100	8%	151,600	15%	189,900	19%	599,200	59%
Iowa	470,000	42,500	9%	72,000	15%	130,600	28%	225,000	48%
Kansas	352,900	35,500	10%	64,100	18%	53,000	15%	200,300	57%
Kentucky	833,900	95,900	12%	215,500	26%	132,200	16%	390,300	47%
Louisiana	1,096,500	112,200	10%	199,000	18%	163,200	15%	622,200	57%
Maine	350,100	55,400	16%	61,500	18%	107,600	31%	125,600	36%
Maryland	753,100	72,500	10%	128,000	17%	168,100	22%	384,600	51%
Massachusetts	1,402,500	157,900	11%	425,500	30%	366,500	26%	452,600	32%
Michigan	1,855,500	136,400	7%	306,800	17%	378,200	20%	1,034,000	56%
Minnesota	785,600	93,500	12%	114,200	15%	187,500	24%	390,500	50%
Mississippi	750,400	93,200	12%	157,300	21%	123,900	17%	376,100	50%
Missouri	1,001,800	94,100	9%	177,500	18%	178,000	18%	552,200	55%
Montana	110,800	10,500	9%	19,600	18%	19,900	18%	60,800	55%
Nebraska	240,900	24,200	10%	34,200	14%	39,400	16%	143,100	59%
Nevada	247,000	24,200	10%	37,300	15%	48,100	19%	137,500	56%
New Hampshire	143,500	14,700	10%	23,000	16%	18,900	13%	86,900	61%
New Jersey	954,000	146,200	15%	162,500	17%	135,900	14%	509,300	53%
New Mexico	501,300	35,000	7%	57,100	11%	106,800	21%	302,400	60%
New York	4,954,600	555,700	11%	635,300	13%	1,805,200	36%	1,958,400	40%
North Carolina	1,645,900	182,900	11%	286,600	17%	311,400	19%	864,900	53%
North Dakota	69,400	9,300	13%	10,600	15%	14,600	21%	35,000	50%
Ohio	2,067,300	177,800	9%	358,300	17%	476,300	23%	1,055,000	51%
Oklahoma	719,200	66,200	9%	104,400	15%	121,100	17%	427,400	59%
Oregon	512,600	51,500	10%	82,200	16%	112,900	22%	266,000	52%
Pennsylvania	2,090,200	233,300	11%	510,700	24%	387,800	19%	958,400	46%
Rhode Island	195,400	24,700	13%	40,600	21%	39,500	20%	90,600	46%
South Carolina	891,600	84,400	9%	142,300	16%	207,200	23%	457,600	51%
South Dakota	122,700	12,500	10%	16,600	14%	20,200	16%	73,400	60%
Tennessee	1,447,100	149,500	10%	296,200	20%	288,100	20%	713,300	49%
Texas	4,170,100	428,900	10%	535,700	13%	526,900	13%	2,678,600	64%
Utah	291,000	15,200	5%	35,900	12%	79,900	27%	160,000	55%
Vermont	157,600	19,900	13%	21,500	14%	50,400	32%	65,900	42%
Virginia	863,300	103,500	12%	156,900	18%	134,500	16%	468,400	54%
Washington	1,163,300	86,900	7%	173,700	15%	269,700	23%	633,000	54%
West Virginia	392,300	40,200	10%	109,000	28%	57,000	15%	186,100	47%
Wisconsin	990,000	153,300	15%	142,700	14%	268,200	27%	425,800	43%
Wyoming	78,100	5,500	7%	9,800	13%	11,600	15%	51,100	65%

Note: Totals may not sum due to rounding.

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2007 MSIS, 2010.

Table 4

Medicaid Payments by Group, FFY 2007

State	Payments (in millions) Total $	Aged $	Aged %	Disabled $	Disabled %	Adult $	Adult %	Children $	Children %
United States	**$300,001**	**$74,180**	**25%**	**$127,278**	**42%**	**$37,166**	**12%**	**$61,378**	**20%**
Alabama	$3,625	$1,066	29%	$1,338	37%	$271	7%	$951	26%
Alaska	$944	$163	17%	$346	37%	$125	13%	$311	33%
Arizona	$6,331	$315	5%	$1,500	24%	$1,727	27%	$2,788	44%
Arkansas	$2,904	$818	28%	$1,266	44%	$131	5%	$690	24%
California	$33,301	$9,017	27%	$13,921	42%	$4,185	13%	$6,178	19%
Colorado	$2,733	$725	27%	$1,185	43%	$255	9%	$568	21%
Connecticut	$3,901	$1,413	36%	$1,477	38%	$306	8%	$706	18%
Delaware	$1,002	$213	21%	$358	36%	$255	25%	$176	18%
District of Columbia	$1,308	$280	21%	$640	49%	$177	14%	$211	16%
Florida	$12,753	$3,375	26%	$5,481	43%	$1,467	12%	$2,429	19%
Georgia	$6,559	$1,204	18%	$2,342	36%	$1,044	16%	$1,968	30%
Hawaii	$1,065	$259	24%	$363	34%	$241	23%	$202	19%
Idaho	$1,082	$201	19%	$548	51%	$105	10%	$228	21%
Illinois	$12,510	$2,098	17%	$5,382	43%	$1,617	13%	$3,413	27%
Indiana	$4,766	$1,006	21%	$2,082	44%	$539	11%	$1,138	24%
Iowa	$2,422	$585	24%	$1,207	50%	$253	10%	$377	16%
Kansas	$2,088	$502	24%	$987	47%	$152	7%	$447	21%
Kentucky	$4,373	$892	20%	$2,038	47%	$506	12%	$936	21%
Louisiana	$4,448	$850	19%	$2,324	52%	$532	12%	$741	17%
Maine	$1,930	$553	29%	$865	45%	$174	9%	$339	18%
Maryland	$5,227	$1,181	23%	$2,510	48%	$541	10%	$996	19%
Massachusetts	$10,505	$2,853	27%	$4,528	43%	$1,285	12%	$1,839	18%
Michigan	$8,646	$2,286	26%	$3,535	41%	$1,148	13%	$1,677	19%
Minnesota	$6,049	$1,510	25%	$2,915	48%	$564	9%	$1,060	18%
Mississippi	$3,062	$852	28%	$1,287	42%	$299	10%	$624	20%
Missouri	$5,780	$1,218	21%	$2,412	42%	$600	10%	$1,550	27%
Montana	$707	$225	32%	$266	38%	$71	10%	$146	21%
Nebraska	$1,460	$378	26%	$611	42%	$103	7%	$369	25%
Nevada	$1,133	$228	20%	$533	47%	$105	9%	$266	24%
New Hampshire	$971	$263	27%	$404	42%	$60	6%	$245	25%
New Jersey	$7,454	$2,349	32%	$3,345	45%	$586	8%	$1,174	16%
New Mexico	$2,563	$400	16%	$998	39%	$358	14%	$806	31%
New York	$41,869	$12,314	29%	$17,930	43%	$7,035	17%	$4,590	11%
North Carolina	$9,329	$1,785	19%	$4,280	46%	$1,079	12%	$2,184	23%
North Dakota	$506	$182	36%	$214	42%	$43	8%	$67	13%
Ohio	$11,951	$3,216	27%	$5,616	47%	$1,354	11%	$1,764	15%
Oklahoma	$3,305	$647	20%	$1,367	41%	$329	10%	$962	29%
Oregon	$2,789	$742	27%	$1,062	38%	$437	16%	$548	20%
Pennsylvania	$14,963	$4,830	32%	$6,264	42%	$1,324	9%	$2,545	17%
Rhode Island	$1,719	$424	25%	$821	48%	$153	9%	$321	19%
South Carolina	$3,697	$810	22%	$1,494	40%	$461	12%	$932	25%
South Dakota	$610	$143	23%	$239	39%	$68	11%	$160	26%
Tennessee	$6,954	$1,200	17%	$3,029	44%	$1,180	17%	$1,545	22%
Texas	$18,996	$3,619	19%	$7,271	38%	$1,678	9%	$6,429	34%
Utah	$1,378	$166	12%	$587	43%	$235	17%	$390	28%
Vermont	$850	$244	29%	$354	42%	$107	13%	$146	17%
Virginia	$4,682	$1,179	25%	$2,161	46%	$398	9%	$944	20%
Washington	$5,427	$1,210	22%	$2,258	42%	$739	14%	$1,220	22%
West Virginia	$2,138	$481	22%	$1,066	50%	$155	7%	$437	20%
Wisconsin	$4,803	$1,613	34%	$2,080	43%	$569	12%	$540	11%
Wyoming	$434	$98	23%	$194	45%	$39	9%	$104	24%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2007 MSIS and CMS-64 reports, 2010.

Table 5

Medicaid Payments Per Enrollee by Group, FFY 2007

State	Payments per Enrollee				
	Total	Aged	Disabled	Adult	Children
United States	**$5,163**	**$12,499**	**$14,481**	**$2,541**	**$2,135**
Alabama	$3,945	$8,538	$6,879	$1,709	$2,155
Alaska	$7,815	$19,143	$23,194	$5,108	$4,261
Arizona	$4,348	$3,473	$10,880	$3,164	$4,092
Arkansas	$4,195	$12,617	$10,529	$982	$1,846
California	$3,168	$9,467	$14,437	$969	$1,445
Colorado	$4,935	$15,003	$15,447	$2,583	$1,723
Connecticut	$7,357	$21,507	$21,650	$2,615	$2,527
Delaware	$5,421	$15,350	$16,041	$3,667	$2,225
District of Columbia	$7,932	$19,188	$19,289	$4,396	$2,740
Florida	$4,487	$8,449	$11,677	$2,854	$1,665
Georgia	$3,892	$7,254	$9,065	$3,773	$2,000
Hawaii	$4,918	$11,307	$14,472	$3,308	$2,111
Idaho	$5,091	$12,391	$15,273	$3,678	$1,728
Illinois	$5,386	$9,567	$18,386	$3,242	$2,602
Indiana	$4,660	$12,255	$13,736	$2,839	$1,899
Iowa	$5,154	$13,771	$16,758	$1,941	$1,675
Kansas	$5,916	$14,128	$15,396	$2,861	$2,234
Kentucky	$5,244	$9,303	$9,456	$3,831	$2,399
Louisiana	$4,056	$7,577	$11,678	$3,262	$1,192
Maine	$5,514	$9,976	$14,062	$1,618	$2,698
Maryland	$6,941	$16,289	$19,606	$3,216	$2,590
Massachusetts	$7,490	$18,069	$10,641	$3,506	$4,064
Michigan	$4,660	$16,762	$11,521	$3,036	$1,622
Minnesota	$7,700	$16,153	$25,525	$3,008	$2,714
Mississippi	$4,080	$9,146	$8,181	$2,410	$1,659
Missouri	$5,769	$12,947	$13,586	$3,370	$2,807
Montana	$6,385	$21,385	$13,578	$3,544	$2,406
Nebraska	$6,062	$15,620	$17,854	$2,604	$2,579
Nevada	$4,586	$9,438	$14,279	$2,192	$1,938
New Hampshire	$6,769	$17,905	$17,550	$3,165	$2,816
New Jersey	$7,814	$16,069	$20,584	$4,312	$2,305
New Mexico	$5,112	$11,443	$17,481	$3,356	$2,664
New York	$8,450	$22,159	$28,223	$3,897	$2,344
North Carolina	$5,668	$9,758	$14,935	$3,466	$2,525
North Dakota	$7,288	$19,572	$20,194	$2,940	$1,908
Ohio	$5,781	$18,087	$15,674	$2,844	$1,672
Oklahoma	$4,595	$9,772	$13,093	$2,716	$2,251
Oregon	$5,441	$14,407	$12,914	$3,873	$2,061
Pennsylvania	$7,159	$20,702	$12,266	$3,414	$2,656
Rhode Island	$8,796	$17,171	$20,220	$3,869	$3,542
South Carolina	$4,146	$9,594	$10,500	$2,224	$2,036
South Dakota	$4,972	$11,415	$14,413	$3,367	$2,182
Tennessee	$4,805	$8,026	$10,226	$4,097	$2,165
Texas	$4,555	$8,437	$13,572	$3,185	$2,400
Utah	$4,737	$10,952	$16,364	$2,940	$2,434
Vermont	$5,394	$12,246	$16,453	$2,124	$2,209
Virginia	$5,424	$11,388	$13,775	$2,962	$2,015
Washington	$4,665	$13,919	$12,999	$2,741	$1,927
West Virginia	$5,450	$11,961	$9,777	$2,713	$2,348
Wisconsin	$4,851	$10,523	$14,574	$2,123	$1,269
Wyoming	$5,561	$17,805	$19,762	$3,326	$2,038

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2007 MSIS and CMS-64 reports, 2010.

Note: Data in this table do not include spending when the service or basis of eligibility of the enrollee is unknown; national per capita spending amounts shown elsewhere in this report are adjusted to include this unknown spending and differ slightly from the totals shown here.

Table 6

Medicaid Income Eligibility as a Percent of Federal Poverty Level (FPL), 2009

State	Infants	Children 1-5	Children 6-19	Pregnant Women	Working Parents*	Childless Adults*
Alabama	133%	133%	100%	133%	24%	NA
Alaska	175%	175%	175%	175%	81%	NA
Arizona	140%	133%	100%	150%	106%	110%
Arkansas	200%	200%	200%	200%	17%	NA
California	200%	133%	100%	200%	106%	NA
Colorado	133%	133%	100%	200%	66%	NA
Connecticut	185%	185%	185%	250%	191%	NA
Delaware	200%	133%	100%	200%	121%	110%
District of Columbia	300%	300%	300%	300%	207%	NA
Florida	200%	133%	100%	185%	53%	NA
Georgia	200%	133%	100%	200%	50%	NA
Hawaii	300%	300%	300%	185%	100%	100% (closed)
Idaho	133%	133%	133%	133%	27%	NA
Illinois	200%	133%	133%	200%	185%	NA
Indiana	200%	150%	150%	200%	25%	NA
Iowa	300%	133%	133%	300%	83%	NA
Kansas	150%	133%	100%	150%	32%	NA
Kentucky	185%	150%	150%	185%	62%	NA
Louisiana	200%	200%	200%	200%	25%	NA
Maine	200%	150%	150%	200%	206%	NA
Maryland	300%	300%	300%	250%	116%	NA
Massachusetts	200%	150%	150%	200%	133%	NA
Michigan	185%	150%	150%	185%	64%	NA
Minnesota	280%	275%	275%	275%	215%	NA
Mississippi	185%	133%	100%	185%	44%	NA
Missouri	185%	150%	150%	185%	25%	NA
Montana	133%	133%	133%	150%	56%	NA
Nebraska	200%	200%	200%	185%	58%	NA
Nevada	133%	133%	100%	185%	88%	NA
New Hampshire	300%	185%	185%	185%	49%	NA
New Jersey	200%	133%	133%	200%	200%	NA
New Mexico	235%	235%	235%	235%	67%	NA
New York	200%	133%	100%	200%	150%	100%
North Carolina	200%	200%	100%	185%	49%	NA
North Dakota	133%	133%	100%	133%	59%	NA
Ohio	200%	200%	200%	200%	90%	NA
Oklahoma	185%	185%	185%	185%	47%	NA
Oregon	133%	133%	100%	185%	40%	NA
Pennsylvania	185%	133%	100%	185%	34%	NA
Rhode Island	250%	250%	250%	250%	181%	NA
South Carolina	185%	150%	150%	185%	89%	NA
South Dakota	140%	140%	140%	133%	52%	NA
Tennessee	185%	133%	100%	250%	129%	NA
Texas	185%	133%	100%	185%	26%	NA
Utah	133%	133%	100%	133%	44%	NA
Vermont	300%	300%	300%	200%	191%	160%
Virginia	133%	133%	133%	200%	29%	NA
Washington	200%	200%	200%	185%	74%	NA
West Virginia	150%	133%	100%	150%	33%	NA
Wisconsin	300%	300%	300%	300%	200%	NA
Wyoming	133%	133%	100%	133%	52%	NA

Source: *A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009* . Data based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, December 2009. Available at http://www.kff.org/medicaid/kcmu120809pkg.cfm. See note below for source of parents and childless adult eligibility levels

* Eligibility for Medicaid or Medicaid Look-Alike coverage. For eligibility levels for programs offering more limited coverage or premium assistance, please see *Where Are States Today: Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults* , Kaiser Commission on Medicaid and the Uninsured analysis of state policies through program websites and contacts with state officials, December 2009. Available at: http://www.kff.org/medicaid/upload/7993.pdf.

Selected Publications from the Kaiser Family Foundation
Available at www.kff.org

The Medicaid Program at a Glance
http://www.kff.org/medicaid/7235.cfm

Medicaid Beneficiaries and Access to Care
http://www.kff.org/medicaid/8000.cfm

Health Coverage of Children: The Role of Medicaid and CHIP
http://www.kff.org/uninsured/7698.cfm

Early and Periodic Screening, Diagnostic, and Treatment Services
http://www.kff.org/medicaid/7397.cfm

Medicaid and Managed Care: Key Data, Trends, and Issues
http://www.kff.org/medicaid/8046.cfm

Filling an Urgent Need: Improving Children's Access to Dental Care in Medicaid and SCHIP
http://www.kff.org/medicaid/7792.cfm

Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries
http://www.kff.org/medicaid/4091.cfm

State Fiscal Conditions and Medicaid
http://www.kff.org/medicaid/7580.cfm

Summary of Coverage Provisions in the Patient Protection and Affordable Care Act
http://www.kff.org/healthreform/8023.cfm

Medicaid and Children's Health Insurance Program Provisions in the New Health Reform Law
http://www.kff.org/healthreform/7952.cfm

Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid's Reach Under Health Care Reform
http://www.kff.org/healthreform/8068.cfm

Expanding Medicaid under Health Reform: A Look at Adults at or below 133% of Poverty
http://www.kff.org/healthreform/8052.cfm

Financing New Medicaid Coverage Under Health Reform: The Role of Federal Government and States
http://www.kff.org/healthreform/8072.cfm

Medicaid Long-Term Services and Supports: Key Changes in the Health Reform Law
http://www.kff.org/healthreform/8079.cfm

The Uninsured: A Primer
http://www.kff.org/uninsured/7451.cfm

Medicare: A Primer
http://www.kff.org/medicare/7615.cfm

THE KAISER COMMISSION ON
Medicaid and the Uninsured

The Henry J. Kaiser Family Foundation

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

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ACCESS TO AND QUALITY OF MEDICAL TREATMENT[1]

Federal Cases

˜ Supreme Court

Estelle v. Gamble, 429 U.S. 97, 103-04, 97 S.Ct. 285, 290-91 (1976)(the key case that established "deliberate indifference to serious medical needs" in the prison context as a constitutional violation:

> An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical torture or a lingering death, the evils of most immediate concern to the drafters of the Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation codifying the common law view that "(i)t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself."

˜ First Circuit

Pagan v. Dubois, 894 F. Supp. 45 (D. Mass 1995) (dismissing for lack of standing claim by U.S. citizens of Latin American origin that prison was failing to give proper medical attention and counseling for HIV+ Latin American prisoners at facility because of lack of Spanish speaking staff).

Pagan v. Dubois, 884 F. Supp. 25 (D. Mass. 1995) (dismissing for lack of harm to class a class action claim by Latin American originated U.S. inmates asserting that lack of Spanish speaking staff caused lack of medical attention and counseling for HIV+ individuals).

˜ Second Circuit

*Parker v. Miller, 199 F.3d 1323, 1999 WL 1024108 (2nd Cir. 1999)(surviving family of deceased inmate with AIDS, who was seriously ill and who died after waiting hours for an ambulance service despite severe pain, bleeding from the mouth, and other serious symptoms, did not establish claim for 8th Amendment violation).

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[1] Please note that this list contains some unpublished cases, which have limited precedential value. Such cases (e.g, unreported cases, unpublished table decisions, unpublished decisions with reported dispositions, etc.) are indicated by an asterisk (*).

Hallett v. New York State Department of Correctional Services, 109 F. Supp 2d 190 (S.D. N.Y. 2000)(adequacy of HIV-related medical care not at issue; but failure for five month period to provide HIV positive amputee with type of wheelchair he could use stated claim for deliberate indifference).

*Carter v. Cash, No. 92-CV-5526 (JG), 1995 WL 347028 (E.D.N.Y. May 31, 1995) (dismissing inmate's claim of improper medical treatment by doctor who failed to proscribe DDC or Interferon, finding doctor denied the drugs based on sound medical judgment).

*Inmates of N.Y. State with Human Immune Deficiency Virus v. Cuomo, No. 90-CV-252, 1991 WL 16032 (N.D.N.Y. Feb. 7, 1991) (discussing discovery dispute involving identification of HIV+ inmates as parties in class action challenging AIDS services in NY prisons).

Nolley v. County of Erie, 776 F. Supp. 715 (W.D.N.Y. 1991) (dismissing inmate's 8th Amm. complaint, finding that prison was merely negligent in late and nondelivery of AZT, and that behavior to not rise to level of constitutional violation).

˜ Third Circuit

*Freed v. Horn, No. 95-CV-2824, 1995 WL 710529 (E.D. Pa. Dec. 1, 1995) (dismissing claim that prison officials were deliberately indifferent to inmate's medical condition in discontinuing prescription of Percoset and switching him to less addictive pain-killers).

McNally v. Prison Health Services, 46 F.Supp. 2d 49 (D. Maine 1999)(where an HIV positive detainee repeatedly informed prison medical personnel that he was following a strict regimen of HIV medication and was deprived of that medication for three days, a jury could find that the defendant was deliverately indifferent to the inmate’s serious medical needs)

˜ Fourth Circuit

Taylor v. Barnett, 105 F.Supp. 2d 483(E.D. Va. 2000)(claim of inmate with AIDS that prison Doctor switched his HIV medications not for medical purposes, but for cost considerations, causing serious side effects and shortening his life, stated a claim for violation of his 8th amendment rights to adequate medical care).

*Williams v. Dehay, No. 94-7114, 94-7115, 1996 WL 128422 (4th Cir. (S.C.) Mar. 21, 1996) (dismissing complaint of HIV+ inmate who claimed prison officials were indifferent to his medical needs in failing to provide narcotics and sleep aids).

McIlwain v. Prince William Hosp., 774 F. Supp. 986 (E.D. Va. 1991) (reversing summary judgment on whether private doctor under contract to prison knowingly and deliberately failed to tell prisoner of prisoner's HIV+ status).

˜ Fifth Circuit

Moore v. Mabus, 976 F.2d 268 (5th Cir. (Miss.) 1992) (vacating dismissal of and appointing counsel for claim asserting lack of medical care for HIV+ inmates).

˜ Sixth Circuit

*Owens v. O'Dea, 149 F.3d 1184, 1998 WL 344063 (6th Cir. 1998)(affirming dismissal of inmates claim of inadequate medical care concerning failure to have an adequate protocol for the treatment of HIV; court reasoned that as Owen's complaints went to the adequacy of the medical care, rather than showing that the defendants acted or failed to act with deliberate indifference, there was no evidence of unconstitutional conduct).

Doe v. Wigginton, 21 F.3d 733 (6th Cir. (Ky.) 1994) (dismissing claim of inmate demanding HIV test, upholding policy of testing only inmates who met criteria establishing them as high risk as furthering legitimate state purpose of insuring efficient use of scarce medical resources).

*Rodgers v. Michigan Dep't of Corrections Medical Dep't, No. 93-1169, 93-1170, 1993 WL 225390 (6th Cir. (Mich.) June 24, 1993) (affirming dismissal of inmate's complaint that he was denied treatment for HIV after two negative HIV tests six months apart).

˜ Seventh Circuit

*Campbell v. Sheahan, No. 94-1184, 1995 WL 649920 (7th Cir. (Ill.) Nov. 2, 1995) (affirming dismissal of inmate's claim that prison failed to provide preventive medical treatment for his HIV+ condition).

˜ Eighth Circuit

Edgington v. Missouri Dep't of Corrections, 52 F.3d 777 (8th Cir. (Mo.) 1995) (dismissing without prejudice for lack of specificity in complaint of pro se inmate that he was denied treatment for his mental and AIDS related illnesses.

˜ Ninth Circuit

*St. Hilaire v. Lewis, No. 93-15129, 1994 WL 245614 (9th Cir. (Ariz.) June 7, 1994) (dismissing claim of prisoner demanding HIV test, finding that it was not a serious medical need because plaintiff was not a member of a high risk group).

*Williams v. Kelly, No. C 93-1141 BAC, 1993 WL 280365 (N.D.Cal. July 13, 1993) (dismissing with leave to amend complaint that officials denied, delayed, or intentionally interfered with medical care of HIV+ inmate, because of insufficiency of facts pleaded).

Casey v. Lewis, 834 F. Supp. 1477 (D. Ariz. Mar. 19, 1993) (finding medical care for mentally ill inmates (including HIV+ inmates) in prison system violated the 8th Amendment.).

*Sullivan v. County of Pierce, 216 F.3d 1084, 2000 WL 432368 (9th Cir. 2000)(reversing district court's grant of summary judgment to jail official, finding that failure to provide detainee with AIDS with his prescribed antiretroviral combination therapy states a claim for deliberate indifference to inmate's serious medical needs).

˜ Tenth Circuit

Perkins v. Kansas Department of Corrections, 165 F.3d 803 (10th Cir. 1999)(providing inmate with HIV disease AZT and 3TC, but not protease inhibitor, showed disagreement of inmate with treatment regimen, and even if malpractice, did not state 8th Amendment claim).

*Fitzhugh v. Wyoming Bd. of Charities and Reform, No. 91-8045, 1992 WL 72959 (10th Cir. (Wyo.) Apr. 10, 1992) (affirming denial of appointment of counsel and reversing denial of extension of discovery time in claim by inmate asserting prison was deliberately indifferent to his HIV+ medical condition).

˜ D.C. Circuit

*Parker v. District of Columbia, No. CIV. A. 93-0600, 1993 WL 381710 (D.D.C. Sept. 9, 1993) (dismissing 8th Amm. claim that HIV+ inmate was being denied AZT and other HIV treatment because lack of medical attention was not deliberate, and dismissing § 1983 negligence claim for qualified immunity).

Reference Guide to HIV as an ADA Disability

Posted By David W. Webber On April 6, 2011 @ 9:13 am In Uncategorized | No Comments

The following listing of ADA provisions (amended in 2008) and EEOC regulations (amended in 2011) focuses on how HIV infection is defined as a disability. The Reference Guide accompanies my essay on the EEOC's new ADA regulation [1].

Key Legal Terms or Concepts

Impairment

- **ADA as amended:** No statutory definition.
- **EEOC:** Includes any physiological disorder or condition affecting one of more body systems, such as the reproductive, immune, hemic, or lymphatic systems. 29 C.F.R. § 1630.2 (h)(1). *See also* Bragdon v. Abbott, 524 U.S. 624, 637 (1998) (holding that HIV infection is an impairment).

Major Life Activity

- **ADA as amended:** Operation of a major bodily function, including functions of the immune and reproductive systems. 42 U.S.C. § 12102(2)(B).
- **EEOC:** Operation of a major bodily function, including functions of the immune system, and hemic, lymphatic, and reproductive functions. 29 C.F.R. § 1630.2(i)(ii).

Remission

- **ADA as amended:** An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active. 42 U.S.C. § 12102(4)(D).
- **EEOC:** An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active. 29 C.F.R. § 1630.2(j)(1)(vii).

Mitigating Measures

- **ADA as amended:** The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures such as … medication [or] medical supplies. 42 U.S.C. § 12102(2)(E)(1).
- **EEOC:** The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures. 29 C.F.R. § 1630.2(j)(1)(vi). Mitigating measures include, but are not limited to, medication and medical supplies. 29 C.F.R. § 1630.2(j)(5)(i).

Inherent Disabilities

- **ADA as amended:** No statutory definition or reference.
- **EEOC:** Individualized assessment of some types of impairments will, in virtually all cases, result in a determination of coverage under the "actual disability" prong or the "record of" prong of the ADA. 29 C.F.R. § 1630.2(j)(3)(ii). Example: Human Immunodeficiency Infection (HIV) substantially limits immune function. 29 C.F.R. § 1630.2(j)(3)(iii). However, there is no "per se" disability. Interpretive Guidance on Title I of the Americans with Disabilities Act, Appendix to Part 1630, 76 Fed. Reg. at 17,011 (Mar. 25, 2011).

Regarded as Having an Impairment

- **ADA as amended:** An individual meets the requirement of "being regarded as having such an impairment" if the individual establishes that he or she has been subjected to an action prohibited under [the ADA] because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity. 42 U.S.C. § 12102(3)(A).
- **EEOC:** An individual is ''regarded as having such an impairment'' if the individual is subjected to a prohibited action because of an actual or perceived physical or mental impairment, whether or not that impairment substantially limits, or is perceived to substantially limit, a major life activity. Prohibited actions include but are not limited to refusal to hire, demotion, placement on involuntary leave, termination, exclusion for failure to meet a qualification standard, harassment, or denial of any other term, condition, or privilege of employment. 29 C.F.R. § 1630.2(l)(1).

URLs in this post:

[1] essay on the EEOC's new ADA regulation: **http://aidsandthelaw.com/wp/?page_id=219**

AFFIDAVIT

_____, being of full age, on her oath, deposes and says:

1. I am a licensed physician in the State of Washington, and specialize in the treatment of adolescent HIV and AIDS. I have been practicing for_____ years.
2. I am the primary physician for [John Doe]. He has been in my care for _____ years.
3. [John Doe] was perinatally infected with HIV. He now is nineteen (19) years of age and has been living with HIV his entire life.
4. Both of John Doe's parents died of AIDS-related complications when he was very little.
5. Despite the loss of his parents and the many challenges that John Doe has faced as a child born with HIV, he has overcome substantial difficulties that many children who are similarly situated do not get beyond. His health and his life are on an even keel, and he currently is enrolled in college. However, for a child like John Doe, the balance of these accomplishments can be delicate and easily threatened by new and significant outside forces.
6. The release of John Doe's medical records, and any criminal justice intervention in his life at this time, is likely to disrupt his education, his ability to maintain his medical regimen, and his physical and mental health and well-being.
7. Doctors and other healthcare providers are uniquely situated to intervene when children's basic needs are not being met. For some youth, such as John

Doe, the child's HIV physician may be one of the more important, long-term and stable adult relationships in the child's life.

8. People living with HIV of all ages face ridicule, ostracism and persecution of all kinds, In its extreme form, hostile expressions of HIV stigma have even driven people from their homes and led to acts of physical violence against them.

9. Because of the societal stigma surrounding HIV, AIDS, and the private behaviors frequently associated with HIV infection, it is widely known that the disclosure of HIV-related information can be very harmful – and even dangerous – for people living with HIV. *See, e.g., Doe v Delie*, 257 F.3d 309, 315 (3d Cir. 2001) ("the privacy interest in information regarding one's HIV status is particularly strong because of the stigma, potential for harassment, and 'risk of much harm from non-consensual dissemination of the information.'" (quoting *Doe v. Se. Pa. Transp. Auth.*, 72 F.3d 1133, 1140 (3d Cir. 1995)).

10. The Centers for Disease Control and Prevention caution healthcare workers to avoid revealing positive HIV test results even to family and friends of patients "[b]ecause of the risk of stigma and discrimination." Centers for Disease Control and Prevention, *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*, Morbidity and Mortality Wkly. Rep. Recommendations and Reps., Sept. 22, 2006, at 10, *available at* http://www.cdc.gov/mmwr/PDF/rr/rr5514.pdf (last visited Feb. 20, 2009).

11. The public health benefits from affording maximum confidentiality protection to HIV-related information are considerable, because "[a] consequence of HIV-

related stigma and discrimination is a negative effect on both HIV prevention efforts as well as care for individuals living with HIV." Brooks, *supra,* at 737; *see also* Margaret A. Chesney & Ashley W. Smith, *Critical Delays In HIV Testing and Care: The Potential Role of Stigma*, 42 Am. Behav. Sci. 1158, 1163- 65 (1999) (discussing research relating stigma to delays in seeking HIV testing and care).

12. It is widely recognized that "[t]he exchange of private information between patient and physician requires 'the patient's ability to trust that the information shared will be protected and kept confidential.'" Melissa Steward, Commentary, *Electronic Medical Records: Privacy, Confidentiality, Liability*, 26 J. Legal Med. 491, 493 (2005) (quoting *Standards for Privacy of Individually Identifiable Health Info., Purpose of the Admin. Simplification Reg.*, 65 Fed. Reg. 82,462, 82,463 (Dec. 28, 2000) (noting importance of confidentiality to development of trusting relationship between doctor and patient)).

13. The ability of doctors to instill trust in people living with HIV – and to get them to confide in their doctors – depends in part on a doctor's ability to reassure his or her patients that their HIV-related information will be held in the strictest of confidence. *See*, *e.g.,* Adam Butera, *HIPAA Preemption Implications For Covered Entities Under State Law*, 37 Tort & Ins. L.J. 1181, 1182 (2002) (noting that "[t]he trust implicit in the doctor/patient relationship is the first casualty of a privacy breach");

14. Concern about HIV-related stigmatization and the isolation it produces can lead people to conceal their HIV status from friends, family and sexual partners. To avoid discovery and potential stigmatization, people with

HIV/AIDS sometimes even forego their HIV medications in the presence of others and, thus, increase their risks of both viral resistance and clinical failure.

15. Because of the support he has received from me and his other care providers, John Doe has been able to disclose his HIV status as appropriate to friends and people close to him. He currently also is compliant with his antiretroviral regimen and consequently has a very low viral load and is in overall good health.

16. In order to maintain continuity of care, it is vitally important that HIV health care providers have a trusting relationship with patients in their care.

17. Building and maintaining a trusting relationship with a young person living with HIV is especially challenging, particularly with children who have grown up without their biological parents and have been dependant on other relatives or the foster care system for their needs and care. Development of this trust is critical if one is going to keep a young person in care, and provide the support necessary for that youngster to maintain a regular schedule with their drug treatment regimen.

18. It can be particularly demanding for a young person to maintain a regular drug treatment regimen for multiple reasons, such as the need to plan, the need to deal with unpleasant side effects such as diarrhea, and the desire to keep their health issues private from peers.

19. I believe that the disclosure of John Doe's medical records will have a severely negative impact on his trust of me and our physician-patient relationship. I also believe it will have a very serious impact on his trust and relationships with other medical and social service providers, whom he has

come to believe have his best interests in mind and whom he expects to protect him and his confidentiality.

20. I do not believe that there is any countervailing public health or other interest that outweighs the harm to John Doe and to his physician-patient relationship that will certainly be caused by release of any portion of his medical records for the purpose of criminal prosecution.

_____ _____

[Name of Affiant} Date

Sworn and subscribed to before me this _____ day of _____, _____.

_____ _____

[Name} Date