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Notes and Comments

PREVENTION, NOT PREJUDICE: THE ROLE OF FEDERAL GUIDELINES IN HIV-CRIMINALIZATION REFORM

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Abstract--Thirty-four states and two U.S. territories have criminal statutes that specifically impose criminal liability for HIV transmission, exposure, or nondisclosure. With possible sentences ranging up to thirty years, these statutes have even provided the basis for convicting HIV-positive individuals who never actually transmitted the virus. To address the unreasonable prosecutions of these individuals, Representative Barbara Lee of California introduced the Repeal Existing Policies that Encourage and Allow Legal HIV Discrimination Act (REPEAL Act) to the U.S. House of Representatives on September 23, 2011. If passed, the REPEAL Act would require a systematic review of these statutes and the development of new federal guidelines to guide nationwide HIV-criminalization reform. This Note investigates the federal government's previous attempts at setting national guidelines for HIV criminalization and offers recommendations for improvements that could be made under the REPEAL Act. In particular, I argue that HIV-specific statues should be reformed, not repealed. To that end, I urge Congress to adopt new federal guidelines that provide clearer notice of scientifically established modes of HIV transmission, set adequate procedural safeguards to prevent unfair prosecutions, establish guidelines for proportionate sentencing, and guarantee adequate federal funding for reform.

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*1404 Introduction

In 2009, Nick Rhoades, an HIV-positive man living in Iowa, received a twenty-five-year prison sentence and was forced to register as a sex offender after having a one-time consensual sexual encounter with another man while using a condom. The other man did not contract HIV as a result of their encounter.[1] In Illinois, an HIV-positive sex worker was jailed after failing to disclose her HIV status to a patron even though a condom wrapper was found at the scene.[2] And even when a local Georgia newspaper had previously published a front-page story about how a woman was living with HIV, a jury still convicted her of HIV nondisclosure, discrediting the evidence she offered that her boyfriend was aware of her status.[3]

***1405** Thirty-four states[4] and two United States territories[5] have criminal statutes or sentencing enhancements that explicitly authorize such prosecutions. These statutes specifically impose criminal liability for HIV/AIDS[6] transmission, exposure,[7] or nondisclosure. Arkansas's statute, for example, states that "[a] person commits the offense of exposing another person to [HIV] if the person knows he or she has tested positive for [[HIV] and . . . engages in sexual penetration with another person without first having informed the other person of the presence of [HIV]."[8] "[S]exual penetration," under Arkansas's statute, not only means sexual intercourse but also "any other intrusion, however slight, . . . of any object into a genital or anal opening of another person's body."[9] The "emission of ***1406** semen is not required" to complete the offense.[10] Arkansas's statute does not provide a defense for condom use or the absence of HIV transmission.

Proponents of these statutes argue that HIV-positive individuals should be punished for not disclosing their status to sexual partners[11] and that the deterrent effect of criminalization promotes public health and prevention strategies.[12] At the same time, many commentators have also recognized that these statutes fuel stigmatization and fear of people living with HIV.[13] These statutes may also undermine public health goals[14] and fail to influence individuals' behavior.[15]

When the disease was first recognized three decades ago,[16] HIV/AIDS was a "puzzle" to doctors.[17] In the early 1990s, when most HIV-specific statutes were adopted, effective antiretroviral drugs were not yet widely ***1407** available.[18] Although HIV was "invariably fatal"[19] in the early stages of the epidemic, medical advances have since made the disease highly treatable.[20] Unfortunately, most HIV-specific statutes have not evolved at the same pace as science.[21]

In recent years, however, momentum has been growing to reform these outdated statutes. In 2010, the Obama Administration released a report encouraging state legislatures to review their HIV-specific statutes "to ensure that they are consistent with current knowledge of HIV transmission and support public health approaches to preventing and treating HIV."[22] On September 23, 2011, Representative Barbara Lee of California introduced the Repeal Existing Policies that Encourage and Allow Legal HIV Discrimination Act (REPEAL Act).[23] The REPEAL Act would require the Attorney General, the Secretary of Health and Human Services, and the Secretary of Defense to work with state officials, organizations, and others to analyze "[f]ederal and [s] tate laws, policies, regulations, and judicial precedents and decisions regarding criminal and related civil commitment cases involving people living with HIV/AIDS."[24] Following this review, the Attorney General would then provide a report on the study's findings, including a set of recommendations for state governments.[25] Federal funding would also be available to help state and local governments and other organizations implement these ***1408** recommendations.[26] If passed,[27] the REPEAL Act would be the first federal law to address the

problems that have developed as a result of HIV criminalization.[28]

The criminalization of HIV exposure has already received considerable treatment in legal scholarship.[29] This Note expands the existing analysis by exploring the appropriate role of the federal government in guiding national reform. Specifically, this Note discusses the historical role of federal guidelines in shaping the national trajectory of HIV-criminalization legislation and offers possible alternative approaches to reforming such guidelines that might encourage nationwide reform at the state level. This Note begins in Part I by discussing the current reality of HIV/AIDS in the United States. This background contextualizes why it is necessary to reform HIV-specific statutes. Next, Part II examines the federal government's two previous sets of federal guidelines for HIV criminalization, specifically, the Presidential Commission Report of 1988[30] and the Ryan White CARE Act of 1990.[31] By exploring the problems related to HIV-specific state statutes, Part III then demonstrates that both the Presidential Commission and the CARE Act provided inadequate guidance. Finally, Part IV proposes alternative approaches the federal government could promote under the REPEAL Act.

I. The Reality of HIV/AIDS in the United States

The Centers for Disease Control and Prevention (CDC) estimates that more than one million people in the United States are currently living with HIV.[32] Every year, approximately 50,000 Americans become infected.[33] And in the United States, nearly 636,000 individuals with AIDS have died ***1409** since the start of the epidemic.[34] Although gay, bisexual, and other men who have sex with men comprise a majority of the new HIV infections every year,[35] the disease affects a cross section of American society.[36]

Approximately 80% of new HIV infections in the United States result from sexual exposure.[37] Contributing to this problem, 18% of HIV-positive individuals are unaware of their HIV status,[38] and a recent study found that such individuals account for most new HIV infections.[39] Additionally, 40% of individuals who are aware of their HIV status do not notify their sexual partners that they have HIV.[40]

The CDC has explained in simplified terms that "HIV is spread by sexual contact with an infected person."[41] But not all sexual contact presents the same degree of risk, and some forms of sexual contact pose almost no risk at all because they do not involve the exchange of blood, semen, or vaginal fluid.[42] Indeed, choice of sex act and condom use both influence the risk of transmission.[43] The risk of transmission, even for the riskiest behavior, is likely lower than commonly believed. For example, the riskiest sex act--unprotected anal sex when the insertive partner is HIV ***1410** positive-- carries about a 1-in-50 probability of transmission.[44] The risk decreases to nearly 1 in 2000 if the HIV-positive individual is the receptive partner during unprotected anal sex.[45] The risks involved with unprotected vaginal sex are also relatively low--"approximately 1 in 1000 for male-to-female transmission and 1 in 2000 for female-to-male transmission."[46] The risk associated with unprotected oral sex has been more difficult to quantify; however, most studies agree that oral sex presents a lower risk of transmission than anal or vaginal sex.[47] Correct and consistent condom use reduces the risk of transmission by at least 90% to 95%.[48] Thus, the risk of an HIV-positive man "transmitting the virus to his partner during a single act of condom-protected anal intercourse is 1 in 500 if the infected man is the insertive partner and 1 in 20,000 if he is the receptive partner."[49] As these statistics demonstrate, transmission of HIV, even through the riskiest sexual contact, is not as easy as it was once assumed to be.

Even when HIV is transmitted, however, there are an increasing number of treatments available. Since the discovery of the virus three decades ago, medical experts have made tremendous advances in developing treatments that delay the progression of HIV to AIDS.[50] Today, ***1411** an antiretroviral drug regimen, which involves taking a combination of three or more drugs that attack the virus and prevent it from multiplying, is typically prescribed.[51] Although these treatments are not a cure,[52] they have transformed HIV from a "death sentence" into a chronic illness.[53] Since 1996, the life expectancy of HIV-positive individuals has more than doubled,[54] and individuals who are still asymptomatic when diagnosed have life expectancies that are approaching that of the general population.[55] Research has shown that these drugs may even reduce the risk of transmission by decreasing an individual's viral load to almost undetectable levels.[56] Unfortunately, HIV-specific statutes have not evolved at the same pace as this ever-increasing wealth of knowledge about infectivity and treatment.[57] As the REPEAL Act recognized, "State and Federal law does not currently reflect the medical advances and discoveries made with regards to HIV/AIDS."[58]

II. A Critical History of the Federal Endorsement of HIV Criminalization

The public hysteria that emerged at the beginning of the HIV/AIDS crisis led many lawmakers to expand the response to the disease beyond ***1412** traditional public health measures[59] and to enact HIV-specific statutes.[60] The federal government supported this approach. This Part focuses on the two major federal endorsements of HIV criminalization--the Presidential Commission Report of 1988 and the Ryan White CARE Act of 1990.

A. The Presidential Commission Report of 1988

In 1987, President Ronald Reagan formed the Presidential Commission on the Human Immunodeficiency Virus Epidemic (the Presidential Commission).[61] The Presidential Commission was tasked not only with evaluating existing efforts to combat HIV but also with making recommendations for future government action.[62] In 1988, the year following its creation, the Presidential Commission published a report comprised of twenty major findings along with hundreds of recommendations intended to comprise the national strategy for responding to the HIV/AIDS epidemic.[63] In a short, two-page section,[64] the Presidential Commission specifically addressed the issue of criminalizing HIV transmission[65] and encouraged state governments "to explore the use of the criminal law in the face of this epidemic."[66] The Presidential Commission cautioned, however, that criminal sanctions should function as a last resort, to be employed only after public health measures and other civil remedies failed to reduce HIV-transmission rates.[67]

The Presidential Commission specifically criticized the use of general criminal laws, such as murder or assault statutes, to criminalize intentional HIV transmission and instead recommended that states consider implementing HIV-specific statutes.[68] It argued that the intent and causation requirements of murder statutes were too difficult to prove in a prosecution for HIV transmission and that the penalties for assault were not ***1413** stringent enough, especially in the case of intentional transmission.[69] In contrast, the report reasoned that HIV-specific statutes "would provide clear notice of socially unacceptable standards of behavior specific to the HIV epidemic and tailor punishment to the specific crime of HIV transmission."[70] Ultimately, the Presidential Commission believed that the implementation of criminal penalties for intentional HIV transmission would deter high-risk behaviors and serve a public health function by preventing the spread of HIV.[71]

The Presidential Commission recognized that relying on criminalization as a prevention strategy could be problematic. The report listed five possible "obstacles to progress."[72] First, it again noted that traditional criminal laws were not "well suited" to HIV-transmission prosecutions.[73] Second, the report stated that prostitution penalties were "too lenient" and that enforcement of prostitution laws was "erratic."[74] Third, the Presidential Commission expressed public health concerns. Adopting criminal sanctions for HIV transmission could divert resources away from effective public health prevention policies.[75] The report even cautioned that criminal sanctions could discourage people from undergoing HIV testing.[76] Fourth, the Presidential Commission recognized that many view criminal sanctions as primarily punitive[77] and as failing to serve as effective deterrents for HIV-positive individuals.[78] Finally, the Presidential Commission acknowledged the dangers of "intrusive policing" and ***1414** "selective prosecution," especially as a means to "harass unpopular groups."[79]

To address these obstacles to progress, the Presidential Commission provided recommendations for HIV-specific statutes. The report recommended that these statutes should only apply to people who have actual knowledge of their HIV-positive status.[80] Furthermore, the statutes should only criminalize behaviors that are "scientifically established mode[s] of transmission" or that are "likely to result in transmission of HIV" "according to scientific research."[81] To that end, the statutes should provide clear notice of specific behaviors that may subject an individual to criminal sanctions.[82] In the context of sexual transmission, the Presidential Commission recommended that statutes specifically impose an affirmative duty on HIV-positive individuals to disclose their HIV status to sex partners, to obtain their partners' consent, and to use precautions.[83] Thus, under the recommendations, only individuals who failed to perform these duties would face prosecution.[84] Consistent with its emphasis on not substituting criminalization for traditional public health efforts, the Presidential Commission also recommended that prosecutors always consult public health officials to discuss other alternatives or interventions before proceeding with an HIV-transmission prosecution.[85] In sum, the Presidential

Commission's recommendations emphasized the need for affirmative defenses, collaboration with public health officials, and clear notice of scientifically established high-risk behavior.

The Presidential Commission's recommendations were a meritorious first attempt to set a national HIV/AIDS strategy. Because it is debatable whether the criminal law has any deterrent effect in a public health context, the recommendations were wise to emphasize that criminal sanctions should only be an adjunct to public health measures. If, as recommended, a system were established for prosecutors to consult public health officials before initiating HIV-transmission prosecutions, less extreme measures ***1415** could be explored first, leaving criminal sanctions only for those extreme cases warranting a heightened response.

As later illustrated by the development of HIV-criminalization statutes at the state level,[86] however, the Presidential Commission's report did not provide adequate guidelines for developing appropriate HIV-specific statutes. First, although the report's broad language concerning scientifically established modes of transmission would provide states the flexibility to update their HIV statutes as science evolved,[87] this broad language was also unnecessarily vague. The recommendations themselves failed to specifically list which high-risk behaviors could be targeted. In 1988, when the report was released, HIV was still widely misunderstood, and many were still unaware of which activities constituted scientifically established modes of transmission. Without clear guidance, the Presidential Commission overlooked an important opportunity to provide accurate information about the actual methods of HIV transmission.

Second, the report's extension of criminal liability only to those HIV-positive individuals who know their status is problematic from a public health perspective. As noted in the report's "obstacles to progress," imposing criminal sanctions only on those individuals who know their status could discourage people from undergoing HIV testing.[88] As a result, it is debatable whether the recommended criminal sanctions would even have the desired deterrent effect and prevent the spread of the disease because any reduction in the number of transmissions attributable to the implementation of criminal liability may be outweighed by an increase in transmissions owing to decreases in HIV testing.

In the end, because the Presidential Commission had no authority to authorize funding to help states implement its recommendations, the success of its report depended largely on whether it received support from Congress. As discussed below, Congress did ultimately support the criminalization of HIV exposure.[89] Contrary to the Presidential Commission's report, however, Congress's requirements did not emphasize limiting HIV criminalization to scientifically established modes of transmission. Thus, as this Note demonstrates, many states' statutes have since undermined the public health strategies designed to prevent the spread of HIV.[90]

*1416 B. The Ryan White CARE Act of 1990

In 1990, Congress supported the Commission's recommendations by passing the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (the CARE Act).[91] The CARE Act was designed to provide emergency financial assistance to state and local governments providing services to HIV-positive individuals and families.[92] Under the CARE Act, however, states would only receive federal funding for HIV/AIDS prevention and relief after demonstrating that "the criminal laws of the State are adequate to prosecute [intentional HIV exposure]."[93] Although a state could satisfy this requirement by enacting an HIV-specific statute, a state could also comply with the requirement if its general criminal laws could apply to intentional transmission.[94] A third option was for states to include HIV in the definition of sexually transmitted infections (STIs) that were covered in existing communicable or infectious disease statutes.[95] Congress repealed the criminalization mandate in 2000, after all states had met the requirement, but to this day, states have still kept their HIV-specific laws on the books.[96]

Although the CARE Act was consistent with the Presidential Commission report's recommendation to rely on criminal prosecution as a prevention measure, the CARE Act ignored many of the report's specific recommendations. The CARE Act identified three means of transmission that state laws must cover: donation of blood, semen, or breast milk; sexual activity; and intravenous drug use.[97] But none of the subsections addressing these activities listed any specific behaviors or made any reference to whether the challenged conduct must be a scientifically established mode of transmission. For example, the CARE Act only required that state criminal

laws be an adequate means to prosecute HIV-positive individuals who engage in "sexual activity," have knowledge of their HIV status, and intend to expose another to HIV.[98] Contrary to the Presidential Commission's recommendations, the CARE Act did not require states to ***1417** provide notice of which specific types of "sexual activity" might be subject to criminal sanction, and it did not require states to limit prosecutions to scientifically established modes of transmission. Furthermore, unlike the Presidential Commission report, the CARE Act only required that state statutes provide an affirmative defense for disclosure and informed consent.[99] The CARE Act neglected to require a defense for individuals who used appropriate protection. By conditioning federal HIV/AIDS funding on such requirements, the CARE Act effectively undermined the Presidential Commission's more public health-oriented goals. As a result, many states implemented statutes that criminalized behaviors that were not scientifically proven to result in HIV transmission.

III. The National Landscape of HIV Criminalization

The Presidential Commission report and the CARE Act served as an impetus for many states to implement HIV-specific criminal statutes. While at least four states had already implemented HIV-exposure statutes in 1988 when the Presidential Commission released its report,[100] by 1993, nearly half the states had HIV-specific statutes.[101] And although the criminalization mandate of the CARE Act was repealed in 2000,[102] no state has since opted to eliminate its HIV-criminalization statute.[103] Today, thirty-four states and two United States territories have HIV-specific criminal statutes.[104]

An examination of these statutes reveals that neither the Presidential Commission report nor the CARE Act provided adequate guidelines for appropriately developing HIV-specific statutes, highlighting the need for reformed federal guidelines. This Part discusses the problems associated with existing HIV-specific criminal statutes. These problems generally fall into three categories--public health, proof, and proportionality. An analysis of these issues serves as the foundation in Part IV for exploring the possibilities for national HIV-criminalization reform.

A. Public Health Problems

Current HIV-specific statutes may impede public health initiatives intended to combat the spread of HIV/AIDS, highlighting the "inevitable tensions" that exist between criminal and public health approaches.[105] Whereas public health initiatives typically emphasize prevention, ***1418** education, voluntariness, and confidentiality, criminal law generally focuses on punishment, deterrence, and incapacitation.[106] Although the prevention and deterrence goals of these two approaches may complement each other, many commentators have nevertheless argued that criminal law inevitably competes with and undermines public health goals.[107] UNAIDS, the joint United Nations program on HIV/AIDS, has argued, for example, that HIV criminalization potentially undermines public health strategies by reinforcing stigma, spreading misinformation about the means of transmission, deterring HIV testing, compromising confidentiality in health care settings, and creating a false sense of security.[108]

Although the Presidential Commission envisioned that HIV-specific statutes would serve as a supplement to public health prevention strategies, the HIV-specific laws that states implemented have instead undermined many public health measures. Contrary to the Presidential Commission's central recommendations,[109] most states' HIV-specific statutes are not limited to scientifically established modes of transmission and do not provide clear notice of which specific behaviors might result in criminal liability. Most states have also neglected to provide adequate affirmative defenses. In particular, most states do not classify condom use as an affirmative defense, even though research shows that using a condom can significantly reduce the risk of transmission.[110] Ultimately, these criminal statutes have not required collaboration with public health officials and have thus undermined many public health strategies.

1. Criminalizing Behaviors that Are Not Scientifically Established Modes of Transmission.--Many states' HIV-specific statutes do not comply with the Presidential Commission's recommendation that criminal sanctions only be used to target behaviors that are scientifically established modes of transmission.[111] Instead, these

statutes enforce an overly broad ban on most forms of sexual activity, regardless of the risk associated with a particular activity. As a result, many statutes conflate low- and high-risk activities with no-risk activities.

***1419** Michigan, for example, requires disclosure before almost any type of sexual contact, including "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."[112] This overly broad statute imposes the same penalty on using an unshared sex toy[113]--a sexual activity that poses no risk of transmission--as it does on engaging in unprotected anal sex. Imposing the same amount of liability on these two very distinct activities not only leads to "unjust, absurd results,"[114] but it also potentially misleads the public about actual modes and risks of transmission.

In addition to criminalizing activities that pose no risk of transmission, many statutes also fail to differentiate between low- and high-risk activities. Idaho's statute defines "transfer" of bodily fluid to include not only engaging in sexual activity by genital-genital and anal-genital contact but also engaging in oral-genital contact.[115] While HIV transmission is still possible through oral sex, the risk is substantially lower than the risk of transmission through vaginal or anal sex.[116] The risk of transmitting the virus through oral sex decreases even further if the person making oral contact is HIV positive.[117] Assuming that the mere risk of transmission justifies criminal sanction, the vast disparity in the degrees of risk associated with various activities raises questions about whether it is appropriate to apply equal punishment to all sexual activity. Ultimately, by failing to take account of the "hierarchy of risk"[118] that exists for various activities, these statutes reduce the incentives for HIV-positive individuals to engage in safer sex and undermine public health and prevention efforts.

2. Lack of Clear Notice.--In addition to both criminalizing behaviors that are not modes of transmission and failing to account for varying degrees of risk, HIV-specific statutes often fail to provide clear notice of prohibited behavior. This lack of clarity is contrary to the Presidential Commission report's recommendation that HIV-exposure statutes "clearly set[] forth those specific behaviors subject to criminal ***1420** sanctions."[119] Instead, the statutes often closely track the language of the CARE Act, which made funding contingent on states imposing liability on any HIV-positive individual who "engages in sexual activity if the individual knows that he or she is infected with HIV."[120] The CARE Act, however, failed to define "sexual activity" anywhere in the statute.

Similarly, Illinois's HIV criminal statute makes it a felony for an HIV-positive individual who is aware of her status to "engage[] in intimate contact with another."[121] The statute defines "intimate contact with another" as "the 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."[122] While this language seemingly tracks the Presidential Commission's recommendation that statutes only criminalize conduct that is a scientifically established mode of transmission, the Illinois law nevertheless illustrates how following the federal recommendation can still result in statutory language that fails to provide clear notice regarding which specific sexual conduct may result in transmission and criminal liability.[123]

This lack of notice is problematic from a public health perspective because it tends to encourage speculation about what constitutes criminal transmission of HIV. Furthermore, the deterrence justification for HIV-specific statutes is weakened if individuals do not have clear notice of which specific behaviors they should not engage in. Because providing clear notice could serve an important public health function by providing accurate information about HIV transmission and thus supplementing prevention goals, new federal guidelines should provide clearer notice of prohibited behaviors.

3. Lack of Adequate Affirmative Defenses.--Finally, the affirmative defenses available under these statutes often do not adequately align with public health strategies of encouraging safe sex and frequent testing. Most HIV-specific statutes adhere to the CARE Act's recommendation of not ***1421** criminalizing conduct if there is disclosure and consent.[124] States typically address disclosure either by making nondisclosure a necessary element of the crime[125] or by making disclosure an affirmative defense.[126] The consequence of this statutory choice affects which party has the burden of proof at trial.[127]

Regardless of the statutory approach addressing disclosure, some have challenged whether disclosure is even a proper requirement in the context of consensual sex.[128] First, an HIV-positive individual only has a duty to

disclose her status if she is actually aware of it. Indeed, as foreshadowed in the "obstacles to progress" that the Presidential Commission identified, criminalizing nondisclosure could discourage people from getting tested.[129] Furthermore, HIV-positive individuals also have an interest in privacy and autonomy.[130] Requiring partner notification may result in subsequent disclosures and may also "raise[] the prospect of domestic violence, loss of family and community support, and discrimination."[131] At the same time, however, sexual partners also have an autonomy interest in making fully informed sexual choices, and informed consent may not be possible without disclosure.[132] Similarly, proponents of HIV-criminalization statutes ***1422** argue that disclosure and consent provisions help prevent the spread of HIV by encouraging HIV-positive individuals to be more cautious when engaging in sexual behavior.[133] Ultimately, however, proving disclosure and consent will be very challenging for HIV-positive defendants who face juries who often are more sympathetic to victims and are biased against individuals living with HIV.[134] These challenges therefore raise questions about whether these requirements promote reliable and just results.

Most problematic is the fact that most HIV-specific statutes lack an affirmative defense for condom use. Missouri's statute goes so far as to explicitly bar even the possibility of a condom defense.[135] But even absent an explicit bar, most states have interpreted their statutes not to allow a condom defense if one is not explicitly provided. In Illinois, for example, an HIV-positive sex worker was jailed after failing to disclose her status to a patron. Although police found a condom wrapper at the scene, under the Illinois statute, a person could be charged with HIV transmission even when a condom was used.[136]

Although providing a condom defense might decrease the incentive to disclose one's HIV status to sex partners, failing to provide a condom defense may more greatly undermine public health strategies that promote safe sex.[137] Professor Isabel Grant argues "that encouraging condom use is so important, and that the use of condoms reduces the risk of transmission so significantly, that the criminal law should distinguish between protected and unprotected sex in cases of nondisclosure."[138] The importance of promoting condom use is also particularly crucial given recent studies that suggest optimism toward new HIV/AIDS treatments has led to "safer sex ***1423** fatigue" and increased sexual risk taking.[139] Especially considering that the vast majority of HIV transmission occurs through sexual contact,[140] the effects of these statutes on the rate of condom use must be closely scrutinized.

B. Proof Problems

The public health problems that HIV-specific statutes create are exacerbated by credibility and evidentiary problems in HIV-exposure prosecutions. While the Presidential Commission focused on the types of conduct that could be criminalized, it failed to provide adequate guidelines on the procedural aspects of HIV prosecutions. The CARE Act failed in this regard as well. These proof problems potentially undermine many of the possible benefits that these statutes could provide.

Credibility is a tremendous hurdle for many HIV-positive defendants. In many consensual-sex cases, the testimony elicited at trial becomes one person's word against another's.[141] For example, in Ginn v. State, a Georgia court of appeals upheld the conviction of Patrice Ginn, an HIV-positive woman, for failing to disclose her HIV status to her boyfriend.[142] The local newspaper in Ginn's town had run a front-page story about her HIV status before she became involved with her boyfriend.[143] Nevertheless, even though Ginn and two witnesses testified that Ginn's boyfriend knew she was HIV positive, the boyfriend testified that Ginn never informed him of her HIV status.[144] Despite overwhelming evidence that her boyfriend knew of her status, the court affirmed Ginn's conviction, explaining that there was at least "some competent evidence support[ing] that Ginn did not disclose her HIV status to the victim before engaging in sexual intercourse."[145] Because of the stigma still attached to being HIV positive, many in Ginn's position face insurmountable hurdles when trying to convince a jury of their credibility in the face of conflicting evidence.[146]

***1424** In addition to credibility problems, HIV-exposure statutes have also created evidentiary problems. By focusing almost exclusively on the defendant's conduct and knowledge, HIV-exposure statutes tend to ignore several problematic issues. First, an HIV-positive individual can be prosecuted under an HIV-exposure statute even if her sex partner was also HIV positive when they had sex.[147] These statutes are silent about whether the alleged victim's own HIV status is relevant. While such an approach may align with a deterrence rationale of

seeking to deter nondisclosure, this approach nevertheless results in criminalizing individuals who have not caused any harm.

Indeed, these statutes often do not require that a victim become infected with HIV as a result of the defendant's conduct.[148] Furthermore, even if transmission does result, these statutes do not require proof that it was the defendant's conduct that caused transmission. This evidentiary problem is particularly apparent under Missouri's HIV-exposure statute, which authorizes prosecutions when "[a]nother person provides evidence of sexual contact with the HIV-infected person after a diagnosis of an HIV status."[149] Thus, under this statute, the prosecution would simply have to prove that the complainant had a sexual relationship with the HIV-positive defendant and that the defendant was aware of her status at the time of the sexual activity; no evidence as to the actual source of transmission is required for conviction.[150] As this statute demonstrates, particularly in the context of exposure during consensual sex, focusing only on the conduct of the HIV-positive defendant undermines the public health strategy of emphasizing joint sexual responsibility[151] and may result in prosecutions that are unfair to HIV-positive defendants.

C. Proportionality Problems

Finally, by failing to provide sentencing guidelines for HIV-exposure crimes, the Presidential Commission and the CARE Act have implicitly promoted inconsistent and disproportionate punishments that are often fueled by fear and stigma. In the absence of federal sentencing guidelines, ***1425** penalties for HIV-exposure crimes are inconsistent from state to state.[152] Even within a single state, however, many statutes result in disproportionate punishment. States have generally followed the recommendation of the Presidential Commission by establishing knowledge of HIV status as sufficient mens rea for the crime.[153] As a result, statutes assign the same punishment to an individual who is reckless as to an individual who acts with the specific intent to transmit the virus.[154] In contrast, the CARE Act recommended that only defendants who intend to expose another to HIV should be liable.[155] But even in states that have HIV-exposure statutes that dictate that "[n]o person shall intentionally expose another to any [AIDS] virus,"[156] courts have interpreted the intent element not to require intent to expose another to HIV or to transmit the virus, but to instead mean intent to engage in the conduct proscribed by the statute.[157] Thus, these statutes often fail to impose varying degrees of punishments depending on the defendant's culpability or the harm the defendant caused.

Additionally, these statutes often authorize disproportionate sentences compared to other comparable crimes. Some scholars have compared the sentences available for HIV exposure and drunk driving. Both crimes are recklessness crimes, where a defendant can be found liable absent actual harm simply by creating a risk of serious harm.[158] Nevertheless, maximum sentences for a first drunk driving offense are generally no longer than a ***1426** year, while sentences for HIV exposure can range anywhere from five to twenty-five years or more.[159] Another scholar has compared the sentences available under HIV-exposure statutes and other general endangerment offenses.[160] While HIV-exposure statutes allow for an average maximum prison sentence of over eleven years, reckless endangerment offenses typically carry sentences of six months to one year.[161] For example, in North Dakota, an HIV-exposure conviction carries a potential prison sentence of up to twenty years; yet a reckless endangerment offense, where "the circumstances manifest [an] extreme indifference to the value of human life," carries a maximum sentence of only five years.[162]

Disproportionate sentencing is also dramatically illustrated by comparing the sentences authorized for HIV-positive sex workers. For example, South Carolina's HIV-exposure statute makes it unlawful for an HIV-positive individual to "knowingly commit an act of prostitution with another person."[163] Although an HIV-negative sex worker would only face a penalty of thirty days to one year in prison,[164] an HIV-positive sex worker could face up to ten years in prison, regardless of whether there was disclosure, consent, and protection.[165] Under South Carolina's criminal code, prostitution is defined as "engaging or offering to engage in sexual activity with or for another in exchange for anything of value."[166] Thus, a sex worker could be charged with prostitution even before engaging in sexual activity. But even assuming that an HIV-positive sex worker engages in sexual activity, the statutory definition of sexual activity could include conduct that does not pose a risk of transmission.[167]

Given the broad range of sexual activity that HIV-exposure statutes typically cover, disproportionate sentences

suggest that it is the person's HIV status, rather than her specific conduct, that is criminalized. Thus, to promote uniformity and to avoid punishments that are prompted by fear and stigma, future federal guidelines should also include clear standards for appropriate sentencing.

*1427 IV. The Role of Federal Guidelines in Promoting National HIV-Criminalization Reform

The Presidential Commission and the Ryan White CARE Act did not provide adequate guidelines for states to develop appropriate HIV-criminalization statutes. As they exist now, HIV-specific statutes simultaneously undermine public health measures and fail to adequately deter high-risk behavior.[168] Nevertheless, as discussed in Part IV.A, because general criminal law statutes create many of the same public health and procedural problems, repealing HIV-specific criminal statutes is not an adequate solution. Instead, this Note argues that Congress should pass the REPEAL Act and adopt new federal guidelines that encourage states to reform, not repeal, their HIV-specific statutes. Because of its focus on the federal government's role in shaping states' HIV-exposure laws, this Note does not attempt to provide a specific model statute that states should implement.[169] Instead, Part IV.B focuses on the areas in which the Attorney General and the federal government can encourage positive reform by providing new HIV-specific guidelines, as would be required under the REPEAL Act. In particular, the new federal guidelines should encourage specificity and scientific accuracy, recommend adequate procedural safeguards, establish guidelines for proportionate punishment, and provide adequate financial incentives for reform.

A. Repealing HIV-Specific Statutes Is Not a Viable Solution

Repealing HIV-exposure statutes and relying instead on general criminal laws would not eliminate the problems discussed in Part III of this Note.[170] HIV-exposure prosecutions under general criminal statutes still present the same public health, proof, and proportionality problems. Nevertheless, many commentators have recommended this approach,[171] arguing that eliminating HIV-specific statutes could help reduce the stigmatization that these statutes perpetuate.[172] Additionally, a traditional criminal law approach might allow prosecutors to take account of the ***1428** varying degrees of risk associated with certain conduct.[173] Similarly, the range of culpability requirements in traditional criminal statutes would allow states to differentiate between reckless or intentional HIV exposure. Currently, this "spectrum of risk and culpability" is not captured in most HIV-specific statutes.[174]

But repealing HIV-specific statutes and instead relying on traditional criminal law is not a workable solution.[175] Prosecuting HIV exposure under traditional criminal laws suffers from the same problems associated with prosecution under current HIV-specific statutes. Criminal laws are often broadly interpreted to sanction conduct that is not a scientifically established mode of transmission. For example, many HIV-positive individuals have been charged with aggravated assault for spitting and biting, with courts finding that HIV constitutes a "deadly weapon."[176] Furthermore, because traditional criminal laws are not specifically designed to deal with disease exposure or transmission, they too fail to give specific notice of the types of activities that could lead to criminal liability.

Likewise, because general criminal laws are not specifically designed for crimes involving sexually transmitted diseases, most do not provide defenses, such as condom use, that are specific to sexual transmission. Finally, HIV-positive defendants face the same credibility and evidentiary problems under general criminal laws. Having identified these problems, the Presidential Commission recognized that "[t]raditional criminal laws are not well suited to the prosecution of HIV transmission" and that HIV-specific solutions were necessary.[177] Thus, federal lawmakers will have to do more than simply recommend the repeal of HIV-specific statutes to correct the problems these statutes have created.

B. Alternative Approaches for Reforming Federal HIV-Criminalization Guidelines

Because repealing HIV-specific statutes is not an optimal solution, Congress should pass the REPEAL Act and provide new federal guidelines to promote national HIV-criminalization reform. There are four main areas in which revised federal guidelines can encourage improvement. First, new guidelines should reinforce the original intent of the Presidential ***1429** Commission by encouraging clear notice of scientifically established

modes of transmission. Next, revised guidelines should provide greater guidance on evidentiary and procedural issues in an effort to combat the bias that HIV-positive defendants often face at trial. Finally, the federal government should establish sentencing guidelines to encourage proportionate punishments and provide adequate financial incentives for reform.

1. Providing Adequate Notice of Scientifically Established Modes of Transmission.--In an effort to eliminate prosecutions for sexual conduct that does not transmit HIV, new federal guidelines should encourage states to provide clear notice of conduct that has been scientifically established as a mode of HIV transmission and that could lead to criminal liability. Two general approaches are possible, each tracking the ongoing rules-versus-standards debate in criminal law.[178] First, revised federal guidelines could follow the approach of the Presidential Commission and maintain a broad standard that recommends criminalizing only behavior that has been scientifically established as a mode of transmission.[179] For example, the guidelines could encourage only criminalizing behaviors that the CDC has recognized as a mode of transmission. Importantly, this approach would allow the guidelines to adapt to scientific developments and would prevent the need for additional legislative reform. Nevertheless, as discussed in Part III, even a science-based standard may not provide sufficient notice of prohibited behavior or prevent prosecutions for no-risk behaviors.[180]

Alternatively, the federal guidelines could take a more rules-based approach, providing a clear list of behaviors that are scientifically established modes of transmission,[181] as well as a list of behaviors that pose little or no risk of transmission.[182] These explicit lists would provide the clear notice that was lacking in the Presidential Commission's ***1430** recommendations and in current HIV-specific statutes. In contrast to the standards approach, providing such lists would "eliminate[] the need to consider medical evidence of transmission risk" and also protect defendants by "allow[ing] less fact finder discretion."[183] Clear lists would also serve the public health function of providing accurate information about which behaviors pose a higher risk of transmission. If the federal guidelines contained a greater degree of scientific specificity, they would no longer be a potential source of misinformation about HIV transmission and would instead supplement prevention efforts.

In contrast to a standards-based approach, however, this rules-based strategy could risk over- or underbreadth as the epidemic changes over time and as new prevention methods and treatments become available.[184] One solution to this problem would be for the federal guidelines to encourage states to include sunset provisions,[185] thus requiring reevaluation of these lists as the epidemic and medical science evolve.[186] Ultimately, because the standards-based approach taken by the Presidential Commission failed to prevent prosecutions for conduct that cannot result in HIV transmission, this rules-based approach may be preferable.

Regardless of whether the guidelines use a standards- or rules-based approach, federal guidelines should explicitly promote condom use. There are three approaches the guidelines could take. First, the federal guidelines could use California's statute as a model by making "sexual activity without the use of a condom" an element of the crime.[187] But given how few states have even addressed condom use,[188] states may be reluctant to follow California's approach. Furthermore, making the absence of protection an element of the offense risks decreasing an HIV-positive individual's motivation to disclose her status to a partner.[189] Alternatively, the guidelines could recommend that states implement an affirmative defense for condom use.[190] Although this second approach does not ***1431** eliminate the nondisclosure problem, it does shift the burden of proof to the defendant. Finally, to address the problem of nondisclosure, the guidelines could consider a compromise by allowing a condom defense only when the HIV-positive individual also disclosed her status.[191] Given the importance of condom use in public health prevention strategies, any of these statutory approaches to promoting condom use would be a great public health improvement in HIV-exposure legislation.

2. Protecting Defendants from Unfair Prosecution.--Given the credibility and evidentiary problems that many HIV-positive defendants face,[192] federal guidelines should encourage procedural requirements that prevent unfair prosecutions. First, the prosecution should have the burden of proving actual transmission. Second, because HIV-positive defendants often face prejudice and discrimination, the burden of proving nondisclosure and consent should also lie with the prosecution. Because a similar debate concerning the burden of proof arose when many states were reforming their rape statutes, related recommendations for rape reform laws is instructive. Ultimately, federal guidelines should be carefully tailored to specifically promote public health and prevention goals.

The first evidentiary issue to consider is whether federal guidelines should recommend adding actual HIV transmission as an element of the offense. Current HIV-exposure statutes target the mere risk of transmission as a sufficient harm warranting criminal sanction. In theory, criminalizing the risk of transmission, rather than actual transmission, may promote public health goals by incentivizing HIV-positive individuals to exercise greater caution with sex partners. Empirical studies, however, have raised doubts about whether these laws actually have the desired deterrent effect.[193] If deterrence is unlikely, the remaining justification for these laws lies in retribution. Under a retributive approach, however, not requiring evidence of actual transmission sends a message that having sex with an HIV-positive individual is itself harmful and further fuels the stigma that is already attached to having HIV.[194] If actual transmission were made an element of the offense, HIV-positive individuals who acted with the intent to transmit HIV but fortuitously failed could still be prosecuted under general criminal statutes, such as for reckless endangerment or assault. HIV-specific statutes would then be limited to those instances where actual ***1432** transmission resulted. This approach would cabin the detrimental, stigmatizing effects of these statutes only for those cases exhibiting the highest degree of harm.

If revised federal guidelines took this actual transmission approach, they could additionally require the prosecution to prove that the victim was HIV-negative prior to his encounter with the defendant and that it was the specific defendant's conduct that resulted in actual transmission to the victim. The prosecution would have two means of demonstrating transmission between the defendant and the alleged victim. First, testing is now available to compare the DNA sequences in HIV strains in two individuals.[195] Alternatively, the prosecution could introduce evidence related to the victim's prior HIV status and sexual history. Placing these evidentiary burdens on the prosecution would help to balance the bias that many HIV-positive defendants face during HIV-exposure prosecutions, would encourage more widespread HIV testing, and would promote greater joint responsibility for choices regarding consensual sex.

Even if federal guidelines did not go so far as requiring actual transmission, other evidentiary approaches could be used to eliminate unfair prosecutions. As discussed in Part III.B, states are split on how to allocate the burden of proving disclosure and consent.[196] A similar debate about where to place the burden of consent developed in the context of reforming rape laws. Comparing these debates will help demonstrate where it is most appropriate to place the burden in HIV-exposure prosecutions.

Advocates of reforming rape laws have argued that the defendant should have the burden of proving consent.[197] This shift was an attempt to move the emphasis away from the rape victim's behavior and to focus instead on the defendant's misconduct.[198] Reformers wanted to avoid "an invitation to put the victim on trial."[199] HIV-exposure laws warrant a different approach. Placing the burden on the prosecution in an HIV-exposure case is appropriate given the different kinds of harm involved in ***1433** HIV exposure and rape. Professor Margo Kaplan illustrates these differences: whereas "[a] defendant is guilty of rape when she engages in sexual activity without the victim's consent," a defendant is guilty of HIV exposure "when she exposes her partner to a risk of sexual activity."[200] Similar differences appear with respect to the type of consent that the two crimes require: "The fact finders in a rape case must determine whether the victim consented to the sexual activity, not whether the victim consented to the defendant creating a risk of the victim being raped. . . . [O]nly consent to the sex itself negates the wrongfulness of the [rape] assault."[201] HIV-exposure statutes, in contrast, "criminalize the creation of risk. The consent defense requires a determination of whether an individual consented to risk . . . ."[202]

Many HIV-exposure statutes incorrectly make consent contingent on an HIV-positive individual's prior disclosure; in other words, if the HIV-positive individual has not disclosed her status, her partner is not able to consent.[203] This approach confuses the harm to which a victim is consenting. Knowledge of a sexual partner's HIV status "is neither necessary nor sufficient for consent to risk of transmission."[204] There is always a degree of risk, however slight, that a sex partner of unknown status is HIV positive or has some other STI.[205] Even if a partner lies about her status by claiming to be HIV negative, the victim still assumes a risk of transmission when he does not insist on using a condom or engaging in low-risk behavior. Ignoring this assumed risk in the context of consensual sex potentially creates a perverse incentive for HIV-negative individuals to avoid taking responsibility for their sexual choices.

In the prosecution context, placing the burden of proving consent entirely on HIV-positive individuals "obscures the fact that both partners involved in a [[consensual] sexual encounter are responsible for taking precautions to prevent the transmission of disease" and "masks the responsibility of uninfected partners to insist

on condom use."[206] Furthermore, whereas rape victims have historically faced stigma in the context of rape prosecutions, HIV-exposure victims do not face the same stigma. To the contrary, it is HIV-positive defendants that must battle a history of marginalization and prejudice, thus warranting an approach that places a greater burden on the prosecution. Therefore, in the context of ***1434** HIV exposure, it is appropriate to place the burden of proving nondisclosure and consent on the prosecution.

3. Setting Guidelines for Proportionate Punishment.--The federal guidelines should encourage states to authorize proportionate sentences for HIV-exposure crimes. The remarkably high sentences available under current HIV-exposure statutes, even when transmission does not result, send the message that sex with an HIV-positive individual is per se harmful.[207] This message is inconsistent with advances in disability law, where the Americans with Disabilities Act has recognized HIV as a disability in an attempt to eliminate the stigma and discrimination attached to HIV status.[208] Broad HIV-exposure laws thus inappropriately "[p]unish[] an HIV-positive individual for her partner's perception of being tainted" and "use[] the expressive power of the criminal law to promote the stigmatization of and discrimination against HIV-positive individuals."[209]

One approach is to recommend that HIV-exposure sanctions be comparable to those available under general STI-exposure statutes.[210] Whereas most HIV-exposure statutes classify the crime as a felony,[211] the penalties under general STI statutes are generally misdemeanors.[212] Indeed, the advances in HIV treatment supports grouping HIV with other STIs.[213] Furthermore, while HIV/AIDS still does kill people, so do other STIs, such as HPV (the human papillomavirus), which can cause cervical cancer.[214] Therefore, setting aside HIV in its own category may no longer be appropriate.

A second approach would be to recommend different sentencing ranges depending on the established mental state of the defendant. Currently, the exclusive focus on knowledge of status results in unreasonable sentences.[215] Instead, a defendant who acted with the intent to transmit HIV should be subject to a harsher sentence than a defendant who ***1435** acted only recklessly or negligently.[216] While the line between intent and knowledge may seem blurry, taking a graded approach would allow prosecutors and courts to distinguish between an HIV-positive individual who repeatedly exposed others to the virus and failed to wear a condom and another HIV-positive individual who, acting on the advice of her doctor that her viral load was low, chose to engage in sexual activities, such as performing oral sex, that have a lower or even negligible risk of transmission.

Finally, the strictest approach would be to only punish individuals who act with the intent to transmit.[217] But even in states that have required proof of intent in the language of their statutes, this intent requirement has been inappropriately interpreted to refer to intent to engage in sexual conduct.[218] Instead, the guidelines should require intent to transmit HIV.[219] To prove intent to transmit, the prosecution could rely on circumstantial evidence, such as whether the defendant disclosed her status or instead lied about having HIV, failed to use a condom or other protection, or had multiple charges brought against her, demonstrating a pattern of high-risk behavior.[220] Some might respond that criminalizing only intentional transmission does not reach broadly enough to sanction HIV-positive individuals who also pose a public health risk by acting knowingly or recklessly. By only criminalizing the highest degree of culpability, however, federal guidelines would place a greater emphasis on joint responsibility in sexual relationships by encouraging condom use and would help eliminate the discrimination that HIV-positive individuals face.

4. Providing Adequate Funding.--Finally, in order to encourage states to follow revised federal guidelines, it is crucial that Congress condition HIV/AIDS funding on states' reforming their statutes in conformance with the guidelines. Without the inducement of federal funding, new federal guidelines would likely be as ineffective as the Presidential Commission report in encouraging appropriate criminal laws. ***1436** Indeed, the CARE Act, which made federal HIV/AIDS funding contingent on states having adequate criminal laws to prosecute exposure,[221] played a large role in the development of HIV-specific statutes. Although only four states had HIV-specific statutes when the Presidential Commission released its report, by 1993--three years after the CARE Act was implemented--nearly half of the states had HIV-specific statutes.[222] By providing new federal funding to implement prevention-oriented HIV-exposure statutes, revised federal guidelines could change the trajectory of HIV criminalization.

Conclusion

Because HIV is now a chronic condition rather than a death sentence, it is necessary to face the fact that consensual sex is a normal part of living a full life, even for individuals living with HIV. The unspoken justification for maintaining existing HIV-specific statutes is that HIV-positive individuals have lost their right to have any sexual contact.[223] This unspoken prohibition is a kind of nonphysical exile of HIV-positive individuals from society.[224] And when HIV-positive individuals dare challenge this exile, the criminal law responds by physically exiling them to prison, often for unreasonable periods of time. Thus, what is really being criminalized is having sex while HIV positive. This problem is frequently ignored, largely because of the tendency to stigmatize people living with HIV.

By passing the REPEAL Act, Congress could address these problems and provide updated guidelines for HIV-criminalization statutes. Guidelines requiring clearly drafted HIV-specific statutes that reflect scientifically established modes of transmission could better supplement public health and prevention efforts. Narrowly tailored HIV-specific statutes could also reduce the risk of unfair and arbitrary prosecutions by establishing higher burdens of proof for the prosecution. By passing the REPEAL Act and providing revised federal guidelines, the federal government would set the standard for national HIV-criminalization reform and end the senseless marginalization of HIV-positive individuals.

Footnotes

1 See Mary Stegmeir, HIV Case Brings 25-Year Sentence, Waterloo-Cedar Falls Courier, May 3, 2009, at B3; Lynda Waddington, HIV-Positive Man's Prison Sentence Shines Light on Iowa Law, Iowa Indep. (June 29, 2009, 10:14 AM), http://iowaindependent.com/16351/hiv-positive-mans-prison-sentence-shines-light-on-iowa-law. Rhoades has since appealed his conviction. See Proof Brief of Applicant/Appellant and Request for Oral Argument, Rhoades v. State, No. 12-0180 (Iowa June 13, 2012).

2 See Mark Shuman, Prostitution Suspect Faces HIV Charge, Chi. Trib., May 6, 1999, § 2, at 2.

3 See Ginn v. State, 667 S.E.2d 712, 714 (Ga. Ct. App. 2008) (crediting the victim's and two witnesses' testimony over the testimony of Ginn and other witnesses). Prosecutions have also taken place in other states for conduct that poses little or no risk of transmission. See, e.g., People v. Hall, No. B190199, 2007 WL 2121912, at *1 (Cal. Ct. App. July 25, 2007) (affirming the felony conviction of a sex worker even though she never engaged in any sexual contact with her patron, the undercover police officer who arrested her); State v. Mubita, 188 P.3d 867, 881-83 (Idaho 2008) (affirming the conviction of an HIV-positive man who performed oral sex on another person).

4 See, e.g., Ark. Code Ann. §§ 5-14-123 (2006), 20-15-903 (2005); Cal. Health & Safety Code §§ 1621.5 (West 2007 & Supp. 2013), 120291 (West 2012); Cal. Penal Code §§647f (West 2010), 12022.85 (West 2012); Fla. Stat. Ann. §§ 381.0041(11)(B) (West 2007 & Supp. 2013), 775.0877 (West 2010 & Supp. 2013), 796.08(5) (West 2007 & Supp. 2013); Idaho Code Ann. §§ 39-601 (2011 & Supp. 2012), -608 (2011); 720 Ill. Comp. Stat. Ann. 5/12-5.01 (West Supp. 2012); Ind. Code Ann. §§ 16-41-7-1, 16-41-14-17 (West 2007), 35-42-1-7 (West 2012 & Supp. 2012), 35-42-1-9 (West 2012), 35-42-2-6(e)-(f) (West 2012 & Supp. 2012), 35-45-16-2(a)-(b), -2(d) (West 2012); Iowa Code Ann. § 709C.1 (West 2003); La. Rev. Stat. Ann. § 14:43.5 (2007); Md. Code Ann., Health-Gen. § 18-601.1 (LexisNexis 2009); Mich. Comp. Laws Ann. §§ 333.5210 (West 2001), .11101 (West 2012); Minn. Stat. Ann. § 609.2241 (West 2009); Mo. Ann. Stat. §§ 191.677 (West 2011), 565.085 (West 2012), 567.020 (West 2012); N.C. Gen. Stat. §§ 130A-25, -144 (2011); N.D. Cent. Code § 12.1-20-17 (2012); S.C. Code Ann. §§ 44-29-60, -140, -145 (2002); Va. Code Ann. §§ 18.2-67.4:1(A)-(B) (2009), 32.1-289.2 (2011); 10A N.C. Admin. Code 41A.0202 (2011). For a comprehensive table listing states that have statutes criminalizing HIV exposure and transmission, see 1 Ctr. for HIV Law & Policy, Ending and Defending Against HIV Criminalization: A Manual for Advocates: State and Federal Laws and Prosecutions 202-05 (2010). Although many of these statutes criminalize HIV exposure through nonsexual means, such as spitting, biting, and donating blood, this Note focuses only on HIV exposure through sexual contact.

5 9 Guam Code Ann. § 28.10 (1996); V.I. Code Ann. tit. 14, § 888 (2012).

[6] The human immunodeficiency virus (HIV) is the virus that causes acquired immune deficiency syndrome (AIDS). Together, they are referred to as "HIV/AIDS." See Basic Information About HIV and AIDS, Ctrs. for Disease Control & Prevention, http://www.cdc.gov/hiv/topics/basic/index.htm#hiv (last modified Apr. 11, 2012) (describing HIV transmission, testing, and prevention).

[7] For the purposes of this Note, I use the term "transmission" to refer to conduct that results in actual HIV infection. I use "exposure" to describe conduct that poses a risk of infection but that does not necessarily result in actual infection. Many states' statutes, however, use the terms "exposure" and "transmission" interchangeably. For example, Illinois has titled its HIV-specific statute "Criminal Transmission of HIV" even though actual infection is not an element of the offense. See 720 Ill. Comp. Stat. Ann. 5/12-5.01(c) ("Nothing in this Section shall be construed to require that an infection with HIV has occurred in order for a person to have committed criminal transmission of HIV.").

[8] Ark. Code Ann. § 5-14-123(b).

[9] Id. § 5-14-123(c)(1) (emphasis added).

[10] Id. § 5-14-123(c)(2).

[11] See, e.g., Isabel Grant, The Boundaries of the Criminal Law: The Criminalization of the Non-Disclosure of HIV, 31 Dalhousie L.J. 123, 177 (2008) (emphasizing the importance of "retribution and the denunciatory function of law"); Sara Klemm, Comment, Keeping Prevention in the Crosshairs: A Better HIV Exposure Law for Maryland, 13 J. Health Care L. & Pol'y 495, 518 (2010) ("[A] person who recklessly or intentionally exposes another to a fatal disease commits a wrong that warrants the social condemnation that a criminal statute represents.").

[12] See, e.g., Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic 130 (1988) [hereinafter Report], available at http://ia700402.us.archive.org/14/items/reportofpresiden00pres/reportofpresiden00pres.pdf ("Establishing criminal penalties for failure to comply with clearly set standards of conduct can also deter HIV-infected individuals from engaging in high-risk behaviors, thus protecting society against the spread of the disease.").

[13] See, e.g., Joint United Nations Programme on HIV/AIDS (UNAIDS), Criminal Law, Public Health and HIV Transmission: A Policy Options Paper 6 (2002) [hereinafter UNAIDS Paper], available at http://data.unaids.org/publications/IRC-pub02/jc733-criminallaw_en.pdf ("Appealing to a desire for retribution in making policy runs the risk of appealing to prejudice and reinforcing discrimination, particularly in the context of the heavy stigma that already often surrounds HIV/AIDS and those individuals or groups associated with it."); Michael L. Closen et al., Discussion, Criminalization of an Epidemic: HIV-AIDS and Criminal Exposure Laws, 46 Ark. L. Rev. 921, 962 (1994) ("Isolating HIV-AIDS for criminalization is one more kind of stigmatization that is not needed for an epidemic that has been plagued by hysteria."); Sean Strub, Ctr. for HIV Law & Policy, AIDS Stigma and the Creation of a Viral Underclass, http:// www.equalitygiving.org/files/eQualityThinking-Why-HIV-Criminalization-Matters/HIV%20CrimBackgrounder_StrubNov11.pdf (discussing how HIV criminalization fuels the stigma associated with HIV).

[14] See, e.g., Rebecca Bennett, Should We Criminalize HIV Transmission?, in The Criminal Justice System and Health Care 225, 227 (Charles A. Erin & Suzanne Ost eds., 2007); Klemm, supra note 11, at 510 ("[T]here is a real danger that these laws communicate messages that at best undermine, and at worst run directly counter to, public health efforts to combat the spread of HIV.").

[15] See, e.g., UNAIDS Paper, supra note 13 ("[I]t is unclear whether criminal sanctions will, in practice, act as a significant deterrent to behaviour that may result in HIV transmission.").

[16] The first news story published about the disease appeared in the New York Native on May 18, 1981. See Larry

Gross, Up from Invisibility: Lesbians, Gay Men, and the Media in America 95 (2001).

17 Jack Begg, 20 Years Ago, the First Clues to the Birth of a Plague, N.Y. Times, June 3, 2001, at WK7 ("AIDS. The acronym alone defines a generation. But 20 years ago, the disease was a puzzle.").

18 See Repeal Existing Policies that Encourage and Allow Legal HIV Discrimination Act (REPEAL Act), H.R. 3053, 112th Cong. § 3(1) (2011).

19 Lawrence K. Altman, Promise and Peril of New Drugs for AIDS, N.Y. Times, Feb. 8, 2000, at F1.

20 See William Jefferson Clinton, Op-Ed., AIDS Is Not a Death Sentence, N.Y. Times, Dec. 1, 2002, at C9 ("[M]edicine can turn AIDS from a death sentence into a chronic illness ...."). Unfortunately, access to treatment is still a challenge in other parts of the world. See Josh Ruxin, AIDS Is Still a Crisis. Is Anyone Really Surprised?, N.Y. Times on the Ground (May 24, 2010, 5:41 PM), http://kristof.blogs.nytimes.com/2010/05/24/aids-is-still-a-crisis-is-anyone-really-surprised/.

21 See REPEAL Act § 3(7) ("State and Federal law does not currently reflect the medical advances and discoveries made with regards to HIV/AIDS."); James B. McArthur, Note, As the Tide Turns: The Changing HIV/AIDS Epidemic and the Criminalization of HIV Exposure, 94 Cornell L. Rev. 707, 707 (2009) ("The HIV/AIDS epidemic is changing, but the criminal law is failing to keep pace." (footnote omitted)).

22 White House Office of Nat'l AIDS Policy, National HIV/AIDS Strategy for the United States 37 (2010), available at http:// www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf.

23 See REPEAL Act. For commentary on the REPEAL Act, see Press Release, Lambda Legal, Positive Justice Project Members Endorse REPEAL HIV Discrimination Act (Sept. 23, 2011), available at http:// www.lambdalegal.org/news/us_20110923_positive-justice-project; Ian S. Thompson, New Legislation Shines Light on the Criminalization of HIV, ACLU Blog of Rights (Sept. 23, 2011, 4:18 PM), http://www.aclu.org/blog/hiv-aids/new-legislation-shines-light-criminalization-hiv; Why Federal Legislation Matters: The REPEAL HIV Discrimination Act, Center for HIV L. & Pol'y (Sept. 26, 2011, 4:19 PM), http://www.hivlawandpolicy.org/posts/view/113.

24 See REPEAL Act § 5(a)(1)-(2).

25 Id. § 5(b).

26 Id. § 6.

27 At the time of publication, the REPEAL Act was still pending in committee.

28 See Why Federal Legislation Matters, supra note 23.

29 See, e.g., Michael L. Closen, The Arkansas Criminal HIV Exposure Law: Statutory Issues, Public Policy Concerns, and Constitutional Objections, 1993 Ark. L. Notes 47; Michael L. Closen & Jeffrey S. Deutschman, A Proposal to Repeal the Illinois HIV Transmission Statute, 78 Ill. B.J. 592 (1990); Carol L. Galletly & Steven D. Pinkerton, Toward Rational Criminal HIV Exposure Laws, 32 J.L. Med. & Ethics 327 (2004); Margo Kaplan, Rethinking HIV-Exposure Crimes, 87 Ind. L.J. 1517 (2012); Kathleen M. Sullivan & Martha A. Field, AIDS and the Coercive Power of the State, 23 Harv. C.R.-C.L. L. Rev. 139 (1988); Leslie E. Wolf & Richard Vezina, Crime and Punishment: Is There a Role for Criminal Law in HIV Prevention Policy?, 25 Whittier L. Rev. 821 (2004); Amy L. McGuire,

Comment, AIDS as a Weapon: Criminal Prosecution of HIV Exposure, 36 Hous. L. Rev. 1787 (1999).

30 Report, supra note 12, at 130-31.

31 Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, Pub. L. No. 101-381, 104 Stat. 576 (codified in scattered sections of 42 U.S.C.) [hereinafter CARE Act].

32 Nat'l Ctr. for HIV/AIDS, Viral Hepatitis, STD & TB Prevention, HIV in the United States: At a Glance 1 (2013) [hereinafter HIV in the U.S.], available at http://www.cdc.gov/hiv/pdf/statistics_basics_factsheet.pdf.

33 Id.

34 Id.

35 Id. (noting that 63% of new infections are found in gay, bisexual, and other men who have sex with men). The rates of infection among people of color are also disproportionately higher. For example, although blacks account for around 12% of the population in the United States, they represented nearly half (44%) of new HIV infections in 2010. See id. at 2.

36 See Sheryl Gay Stolberg, In AIDS War, New Weapons and New Victims, N.Y. Times, June 3, 2001, at 1 (explaining that HIV also affects women, intravenous drug users, blacks, whites, and Hispanics of all socioeconomic levels).

37 Gary Marks, Nicole Crepaz & Robert S. Janssen, Estimating Sexual Transmission of HIV from Persons Aware and Unaware that They Are Infected with the Virus in the USA, 20 AIDS 1447, 1449 (2006).

38 HIV in the U.S., supra note 32; see also Richard Knox, Many Americans with HIV Don't Know They Have It, NPR (Nov. 24, 2008), http:// www.npr.org/templates/story/story.php?storyId=97315837 ("More than 20 percent of people with HIV--more than 200,000 people--are unaware they're infected, ... slightly better than the 25 percent 'unaware' rate of 2005." (internal quotation marks omitted)).

39 Marks, Crepaz & Janssen, supra note 37, at 1448-49 ("[W]e conservatively estimate that just over half of new sexually transmitted HIV infections in the USA stem from ... infected persons in the USA who are unaware of their [HIV] status.").

40 Mike Allen et al., Persons Living with HIV: Disclosure to Sexual Partners, 25 Comm. Res. Reps. 192, 196 (2008).

41 Ctrs. for Disease Control & Prevention, HIV and Its Transmission 1 (1999), available at http://img.thebody.com/cdc/pdfs/transmission.pdf.

42 See Galletly & Pinkerton, supra note 29, at 329-30 (discussing how various state statutes presumably criminalize using noncontaminated sex toys, engaging in manual or digital stimulation of a partner, and kissing, though these acts pose almost no risk of transmission).

43 See Beena Varghese et al., Reducing the Risk of Sexual HIV Transmission: Quantifying the Per-Act Risk for HIV on the Basis of Choice of Partner, Sex Act, and Condom Use, 29 Sexually Transmitted Diseases 38 (2002).

44 Galletly & Pinkerton, supra note 29, at 328; see also Varghese et al., supra note 43, at 40 (per-act risk of HIV

infection of 5 in 1000); Eric Vittinghoff et al., Per-Contact Risk of Human Immunodeficiency Virus Transmission Between Male Sexual Partners, 150 Am. J. of Epidemiology 306, 309 (1999) (per-contact risk of 0.82%). Although these per-act numbers may seem low, the cumulative risk of transmission increases with every sexual contact. See Varghese et al., supra note 43, at 41.

45 Galletly & Pinkerton, supra note 29, at 328; see also Vittinghoff et al., supra note 44 (estimating a per-contact risk of 0.06%).

46 Galletly & Pinkerton, supra note 29, at 328 (footnote omitted); see also Marie-Claude Boily et al., Heterosexual Risk of HIV-1 Infection per Sexual Act: Systematic Review and Meta-Analysis of Observational Studies, 9 Lancet Infectious Diseases 118, 122 (2009) (estimating 0.04% per-act risk for female-to-male transmission and 0.08% per-act risk for male-to-female transmission in high-income countries). As of 2006, the CDC reported that there were "no confirmed cases of female-to-female sexual transmission." Ctrs. for Disease Control & Prevention, HIV/AIDS Among Women who Have Sex with Women 1 (2006), available at http://www.cdc.gov/hiv/topics/women/resources/factsheets/pdf/wsw.pdf.

47 See Rebecca F. Baggaley, Richard G. White & Marie-Claude Boily, Systematic Review of Orogenital HIV-1 Transmission Probabilities, 37 Int'l J. of Epidemiology 1255, 1255 (2008); Jorge del Romero et al., Evaluating the Risk of HIV Transmission Through Unprotected Orogenital Sex, 16 AIDS 1296, 1296 (2002). Unprotected oral sex where the receptive partner--the individual receiving oral stimulation--is HIV positive, however, is not negligible. See Vittinghoff et al., supra note 44 (estimating that the per-contact risk for unprotected receptive oral sex is 0.06% or less).

48 Steven D. Pinkerton & Paul R. Abramson, Condoms and the Prevention of AIDS, 85 Am. Scientist 364, 368 (1997) ("When used consistently and correctly, the effectiveness of condoms is probably much greater than these figures imply--as much as 99.5 percent.").

49 Galletly & Pinkerton, supra note 29, at 328.

50 There are currently thirty-one FDA-approved antiretroviral medications. See AIDSinfo, FDA-Approved Anti-HIV Medications (2012), available at http://www.aidsinfo.nih.gov/ContentFiles/ApprovedMedstoTreatHIV_FS_en.pdf; see also Jay A. Levy, Not an HIV Cure, but Encouraging New Directions, 360 New Eng. J. Med. 724, 724 (2009) ("Currently, infected patients can benefit from antiretroviral therapies that effectively delay or prevent progression to AIDS. These people are in many cases healthy but continue to carry HIV." (footnote omitted)).

51 See AIDSinfo, supra note 50; Julio S.G. Montaner et al., Association of Highly Active Antiretroviral Therapy Coverage, Population Viral Load, and Yearly New HIV Diagnoses in British Columbia, Canada: A Population-Based Study, 376 Lancet 532, 532 (2010). The FDA also recently approved the use of Truvada, an antiretroviral drug, as a prophylactic measure for people who are at a higher risk for HIV infection. See Drug Approved to Fight H.I.V. Infection, N.Y. Times, July 17, 2012, at A16; see also J.M. Baeten et al., Antiretroviral Prophylaxis for HIV Prevention in Heterosexual Men and Women, 367 New Eng. J. Med. 399, 399 (2012) (finding that antiretroviral prophylaxis reduced the rate of HIV transmission by about 67%-75%).

52 Although no cure has been identified yet, researchers are still hopeful. See Erin Loury, Berlin Patient, First Person Cured of HIV, May Soon Have Company, L.A. Times Booster Shots (July 27, 2012), http://www.latimes.com/health/boostershots/la-heb-hiv-cure-aids-meeting-20120727,0,960052.story.

53 See Clinton, supra note 20.

54 See Kathleen McDavid Harrison, Ruiguang Song & Xinjian Zhang, Life Expectancy After HIV Diagnosis Based on National HIV Surveillance Data from 25 States, United States, 53 J. AIDS 124, 125 (2010).

[55] See Ard van Sighem et al., Life Expectancy of Recently Diagnosed Asymptomatic HIV-Infected Patients Approaches that of Uninfected Individuals, 24 AIDS 1527, 1528 (2010).

[56] See Donald G. McNeil, Jr., Early Therapy for H.I.V. Said to Cut Spread, N.Y. Times, May 13, 2011, at A1; Press Release, Nat'l Inst. of Allergy & Infectious Diseases, Treating HIV-Infected People with Antiretrovirals Protects Partners from Infection (May 12, 2011), available at http://www.niaid.nih.gov/news/newsreleases/2011/Pages/HPTN052.aspx.

[57] See McArthur, supra note 21.

[58] REPEAL Act, H.R. 3053, 112th Cong. § 3(7) (2011).

[59] See generally Sullivan & Field, supra note 29 (discussing quarantine and criminalization as responses to AIDS).

[60] Cf. Stephen V. Kenney, Comment, Criminalizing HIV Transmission: Lessons from History and a Model for the Future, 8 J. Contemp. Health L. & Pol'y 245 (1992) (comparing the responses to syphilis and AIDS).

[61] Exec. Order No. 12,601, 52 Fed. Reg. 24,129 (June 29, 1987).

[62] Id.

[63] See Report, supra note 12.

[64] See id. at 130-31.

[65] Although the section on criminalization was titled "Criminalization of HIV Transmission," id. at 130, the Presidential Commission likely intended its recommendations to apply to HIV exposure as well. It recommended that HIV-specific criminal statutes be "directed to those HIV-infected individuals who know of their status and engage in behaviors which they know are ... likely to result in transmission of HIV." Id. at 131 (emphasis added). Because the report used the word "transmission," this Note will likewise use that terminology when discussing the report.

[66] Id. at 130.

[67] See id.

[68] See id.

[69] See id.

[70] Id.

[71] See id.

[72] Id.

[73] Id.

[74] Id.

[75] See id. Other commentators raised this same concern. See Larry Gostin, The Politics of AIDS: Compulsory State Powers, Public Health, and Civil Liberties, 49 Ohio St. L.J. 1017, 1058 (1989) ("Public policy aimed at isolating or criminalizing AIDS transmission may appear to be getting tough with the disease. But they divert our attention and resources from the policies that would make a real difference--focused education, testing, counseling, and treatment for drug dependency."); Scott A. McCabe, Rejecting Inference of Intent to Murder for Knowingly Exposing Another to a Risk of HIV Transmission, 56 Md. L. Rev. 762, 775 (1997) ("Criminalization ... may divert limited resources away from testing, treatment, and educational programs in order to pay lawyers fees, court costs, and prison expenses.").

[76] See Report, supra note 12; see also Klemm, supra note 11, at 508-09 (discussing concerns that criminal HIV-exposure laws discourage testing); Erin M. O'Toole, Note, HIV-Specific Crime Legislation: Targeting an Epidemic for Criminal Prosecution, 10 J.L. & Health 183, 201 (1995-1996) ("HIV-specific crime statutes which authorize disclosure of confidential voluntary HIV test results might serve to actually increase the public health risk by discouraging voluntary testing."). But cf. Klemm, supra note 11, at 509 & n.114 (suggesting that HIV statutes may not actually have this effect).

[77] See generally J. Kelly Strader, Criminalization as a Policy Response to a Public Health Crisis, 27 J. Marshall L. Rev. 435 (1994) (discussing the general theories for criminalizing HIV exposure).

[78] See Report, supra note 12.

[79] Id.; see also Donald H.J. Hermann, Criminalizing Conduct Related to HIV Transmission, 9 St. Louis U. Pub. L. Rev. 351, 357 (1990) ("There is a concern that such statutes may be selectively applied against gay men and other minority or unpopular groups."). Some commentators have drawn parallels between the selective enforcement of criminal sodomy laws and HIV-exposure statutes, arguing that they "could become a tool of official persecution--an outlet for irrational fear and hostility toward gay men." Sullivan & Field, supra note 29, at 189-90; see also Wolf & Vezina, supra note 29, at 871 ("The selection of cases for prosecution may be discriminatory, as has occurred with some sodomy prosecutions.").

[80] See Report, supra note 12, at 131.

[81] Id.

[82] See id.

[83] See id.

[84] See id.

[85] See id.

[86] See infra Part III.

[87] James McArthur argues that a "generalizing statute" could be beneficial because it would "avoid obsolescence as the HIV/AIDS epidemic changes." McArthur, supra note 21, at 738. In contrast, a "specifying reform" could be problematic because "defining behavior in the context of a changing epidemic carries the significant risk of over- or underbreadth should new events change the epidemic even further." Id. at 737.

[88] See supra note 76 and accompanying text.

[89] See infra Part II.B.

[90] See infra Part III.

[91] Pub. L. No. 101-381, 104 Stat. 576 (codified in scattered sections of 42 U.S.C.). For a more comprehensive discussion of the CARE Act, see Raymond C. O'Brien, A Legislative Initiative: The Ryan White Comprehensive AIDS Resources Emergency Act of 1990, 7 J. Contemp. Health L. & Pol'y 183 (1991). The Act was named after an HIV-positive teenager who fought to attend public school after the superintendant of his school banned him from attending classes because of his HIV status. See Dirk Johnson, Ryan White Dies of AIDS at 18; His Struggle Helped Pierce Myths, N.Y. Times, Apr. 9, 1990, at D10.

[92] See CARE Act § 2 (codified at 42 U.S.C. § 300ff (2006)).

[93] Id. § 2647(a) (codified at 42 U.S.C. § 300ff-47) (repealed 2000).

[94] See id. § 2647(c).

[95] See Kenney, supra note 60, at 263.

[96] See Ryan White CARE Act Amendments of 2000, Pub. L. No. 106-345, § 301(a), 114 Stat. 1345; Wolf & Vezina, supra note 29, at 840-41.

[97] CARE Act § 2647(a)(1)-(3).

[98] Id. § 2647(a)(2).

[99] See id. § 2647(b).

[100] Report, supra note 12 (listing Florida, Idaho, Louisiana, and Nevada).

[101] REPEAL Act, H.R. 3053, 112th Cong. § 3(6) (2011).

[102] See supra note 96 and accompanying text.

[103] See Strub, supra note 13, at 2-3.

[104] See supra notes 4-5 and accompanying text. For a comprehensive summary of state and federal laws criminalizing HIV exposure and transmission, see 1 Ctr. for HIV Law & Policy, supra note 4.

[105] Klemm, supra note 11, at 505.

[106] See id. at 505-07 (discussing the tensions between public health initiatives and criminal law). The incapacitation argument may be particularly weak because "those who are convicted, particularly those who do harbor the intent to infect others, are sent to prison where access to condoms is rare and rape is a significant problem." Id. at 510 (footnote omitted).

[107] See supra note 14 and accompanying text.

[108] UNAIDS Paper, supra note 13, at 23-25.

[109] See Report, supra note 12, at 131 (recommending affirmative duties of disclosure, consent, and protection, clear notice of scientifically established modes of transmission, and collaboration with public health officials).

[110] See supra note 48 and accompanying text.

[111] See, e.g., supra notes 8-10 and accompanying text. But cf. Ind. Code Ann. § 16-41-7-1(b) (West 2007) (defining "high risk activity" as "sexual or needle sharing contact that has been demonstrated epidemiologically to transmit [HIV, AIDS, or Hepatitis B]").

[112] Mich. Comp. Laws Ann. § 333.5210(2) (West 2001) (emphasis added) (defining "sexual penetration"). Arkansas's statute has an identical definition of sexual penetration. See Ark. Code Ann. § 5-14-123(c)(1) (2006).

[113] See Galletly & Pinkerton, supra note 29, at 329 ("[T]he statutes do not criminalize sharing objects that have been exposed to the bodily fluids of someone who has HIV. Instead, the statutes prohibit the 'intrusion' of an 'object' ... with no mention of the object being HIV-contaminated or shared.").

[114] Scott Burris et al., Do Criminal Laws Influence HIV Risk Behavior? An Empirical Trial, 39 Ariz. St. L.J. 467, 486 (2007).

[115] Idaho Code Ann. § 39-608(2)(b) (2011).

[116] See supra note 47 and accompanying text.

[117] See supra note 47 and accompanying text.

[118] Burris et al., supra note 114, at 486 n.98.

[119] Report, supra note 12, at 131.

[120] CARE Act of 1990, Pub. L. No. 101-381, § 2647(a)(2), 104 Stat. 576 (codified at 42 U.S.C. § 300ff-47) (not defining "sexual activity" anywhere in the statute) (repealed 2000).

[121] 720 Ill. Comp. Stat. Ann. 5/12-5.01(a)(1) (West Supp. 2012).

[122] Id. § 5/12-5.01(b).

[123] Despite the Illinois statute's vagueness, it has survived constitutional challenges. See People v. Russell, 630 N.E.2d 794 (Ill. 1994); People v. Dempsey, 610 N.E.2d 208 (Ill. App. Ct. 1993). Other states' statutes have also survived constitutional challenges. See, e.g., State v. Keene, 629 N.W.2d 360 (Iowa 2001); People v. Jensen, 586 N.W.2d 748 (Mich. Ct. App. 1998); State v. Mahan, 971 S.W.2d 307 (Mo. 1998); State v. Gonzalez, 796 N.E.2d 12 (Ohio Ct. App. 2003). See generally Klemm, supra note 11, at 503 (describing unsuccessful constitutional challenges to HIV-specific statutes in several states).

[124] See CARE Act § 2647(b) ("The State laws ... need not apply ... if the individual who is subjected to the behavior involved knows that the other individual is infected and provides prior informed consent to the activity.").

[125] See, e.g., Ark. Code Ann. § 5-14-123(b) (2006) ("A person commits the offense of exposing another person to [HIV] if the person knows he or she has tested positive for [HIV] and ... engages in sexual penetration with another person without first having informed the other person of the presence of [HIV].").

[126] See, e.g., 720 Ill. Comp. Stat. Ann. 5/12-5.01(d) ("It shall be an affirmative defense that the person exposed knew that the infected person was infected with HIV, knew that the action could result in infection with HIV, and consented to the action with that knowledge."); Iowa Code Ann. § 709C.1(5) (West 2003) ("It is an affirmative defense that the person exposed to [HIV] knew that the infected person had a positive [HIV] status at the time of the action of exposure, knew that the action of exposure could result in transmission of [HIV], and consented to the action of exposure with that knowledge.").

[127] Where nondisclosure is an element of the crime, the prosecutor will have to prove, beyond a reasonable doubt, that the defendant failed to disclose her HIV status. In a statute that treats disclosure as an affirmative defense, however, it is the defendant who carries the burden of establishing that she disclosed her HIV status. In these states, the prosecutor then only has to establish that the defendant knew she was HIV-positive before engaging in prohibited conduct. See Galletly & Pinkerton, supra note 29, at 333.

[128] Cf. Kaplan, supra note 29, at 1542 ("[T]he fact finder should also consider the defendant's interests in non-disclosure. An HIV-positive individual may have significant interests in keeping her [HIV] status private." (footnote omitted)).

[129] See supra note 76 and accompanying text.

[130] See Lawrence O. Gostin & James G. Hodge, Jr., Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification, 5 Duke J. Gender L. & Pol'y 9, 66 (1998) ("Persons with infection suggest that principles of respect for autonomy militate in favor of privacy.").

[131] Kaplan, supra note 29, at 1558.

[132] See Gostin & Hodge, supra note 130, at 66-67.

[133] See Galletly & Pinkerton, supra note 29, at 333 ("To the extent that the use of condoms or other prophylactics is a

cautionary action, and to the extent that disclosure and informed consent, while not protective in themselves, will likely lead to a partner requesting less risky behavior, the more cautious a potential defendant's behavior is, the less likely it is that he or she is intending to transmit HIV to a partner.").

134 See infra notes 141-46 and accompanying text.

135 Missouri's HIV statute explicitly bars the possibility of a condom defense. See Mo. Ann. Stat. § 191.677(4) (West 2011). But see Cal. Health & Safety Code § 120291(a), (b)(2) (West 2012) (criminalizing only unprotected sex, or "sexual activity without the use of a condom"). Minnesota's HIV statute also recognizes the importance of condom use. Although it criminalizes "[s]exual penetration," it limits the definition of sexual penetration to certain sexual acts "committed without the use of a latex or other effective barrier." Minn. Stat. Ann. §609.2241(1)(e) (West 2009). North Dakota and North Carolina also provide condom defenses. Their condom defenses, however, are only available if the HIV-positive individual also disclosed her status. See N.D. Cent. Code § 12.1-20-17(3) (2012) ("It is an affirmative defense to a prosecution under this section that if the transfer was by sexual activity, the sexual activity took place between consenting adults after full disclosure of the risk of such activity and with the use of an appropriate prophylactic device." (emphasis added)); 10A N.C. Admin. Code 41A.0202 (2007).

136 See Shuman, supra note 2.

137 See Isabel Grant, Rethinking Risk: The Relevance of Condoms and Viral Load in HIV Nondisclosure Prosecutions, 54 McGill L.J. 389, 400 (2009).

138 Id. at 392.

139 David E. Ostrow et al., Attitudes Towards Highly Active Antiretroviral Therapy Are Associated with Sexual Risk Taking Among HIV-Infected and Uninfected Homosexual Men, 16 AIDS 775, 779 (2002). But cf. Burris et al., supra note 114, at 472 ("We see no sign in our data of the phenomenon of 'moral hazard'--the uninfected taking more chances in the belief that the infected are following legal rules of condom use or disclosure.").

140 See supra note 37 and accompanying text.

141 See McArthur, supra note 21, at 739.

142 667 S.E.2d 712, 714 (Ga. Ct. App. 2008).

143 Id. at 713.

144 Id. at 714.

145 Id.

146 In another Georgia case involving similar disclosure issues, an HIV-positive man was sentenced to two years in prison and eight years of probation for failing to disclose his status to a woman with whom he had sex at his home, the Rainbow Center--a housing center for people living with HIV. See Amy Leigh Womack, HIV-Positive Man Jailed for Not Disclosing His Diagnosis, Telegraph (Macon), Jan. 13, 2009, at 1A.

147 Cf. W. Thomas Minahan, Disclosure Before Exposure: A Review of Ohio's HIV Criminalization Statutes, 35 Ohio

N.U. L. Rev. 83, 102 (2009) ("Ironically, under the [Ohio] felonious assault statute as it is now written, two individuals, who are both infected with HIV, could each be convicted if they have intimate relations with each other and fail to disclose their [HIV status].").

148 In fact, several states explicitly state that actual transmission is not an element of the offense. See, e.g., 720 Ill. Comp. Stat. Ann. 5/12-5.01(c) (West Supp. 2012) ("Nothing in this Section shall be construed to require that an infection with HIV has occurred in order for a person to have committed criminal transmission of HIV.").

149 Mo. Ann. Stat. § 191.677(1)(2)(c)(c) (West 2011).

150 See Ctr. for HIV Law & Policy, supra note 4, at 102.

151 See infra note 206 and accompanying text.

152 Cf. Closen et al., supra note 13, at 954 ("If conduct is offensive in some manner, it should be consistently offensive across the board. It should not be more offensive in Illinois than it is in Florida. However, there is no consistency in the potential punishment for essentially the same acts from state to state."). Compare Iowa Code Ann. §§ 709C.1 (West 2003), 902.9 (West 2003 & Supp. 2013) (classifying HIV exposure as a class B felony subject to imprisonment not to exceed twenty-five years), with Md. Code Ann., Health-Gen. § 18-601.1(b) (LexisNexis 2009) (classifying HIV exposure as a misdemeanor subject to imprisonment not to exceed three years).

153 See Report, supra note 12, at 131; see, e.g., Ark. Code Ann. § 5-14-123(b) (2006) ("A person commits the offense of exposing another person to [HIV] if the person knows he or she has tested positive for [HIV] and ... engages in sexual penetration with another person without first having informed the other person of the presence of [HIV]." (emphasis added)).

154 See Kaplan, supra note 29, at 1532 (noting that extending liability based solely on knowledge of status "includes within its sweep those without a blameworthy mental state as to transmission while excluding some individuals who are reckless or intend to transmit. It also results in disproportionate punishment by failing to distinguish individuals who intend harm from those who are merely reckless or negligent.").

155 CARE Act of 1990, Pub. L. No. 101-381, § 2647(a)(2), 104 Stat. 576 (codified in 42 U.S.C. § 300ff-47 (2006)) (stating that criminal laws should be available to prosecute an HIV-positive individual who "engages in sexual activity if the individual knows that he or she is infected with HIV and intends, through such sexual activity, to expose another to HIV" (emphasis added)).

156 La. Rev. Stat. Ann. § 14:43.5(A) (2007) (emphasis added).

157 See, e.g., State v. Roberts, 844 So. 2d 263, 272 (La. Ct. App. 2003) ("La. R.S. [43.5] does not require the State to prove that a defendant acted with the specific intent to expose the victim to [HIV]; rather, it requires the State to prove that the defendant intentionally committed an act proscribed by the statute which exposed the victim to [HIV].").

158 See Wolf & Vezina, supra note 29, at 872.

159 See id.

160 See Kaplan, supra note 29, at 1536-37 (comparing the sentences for endangerment and HIV-exposure offenses in states that proscribe both offenses).

[161] See id.

[162] Compare N.D. Cent. Code § 12.1-20-17 (2012), with id. § 12.1-17-03 (2012). See generally id. § 12.1-32-01 (2012) (defining the penalties for each classification of offense). For a more comprehensive comparison of possible sentences under various states' endangerment and HIV-exposure statutes, see Kaplan, supra note 29, at 1537-38 tbl.2.

[163] S.C. Code Ann. § 44-29-145(2) (2002).

[164] Id. § 16-15-110 (2003).

[165] Id. § 44-29-145.

[166] Id. § 16-15-375(4) (2003) (emphasis added).

[167] See id. § 16-15-375(5).

[168] See supra notes 14-15 and accompanying text.

[169] Cf. Galletly & Pinkerton, supra note 29, at 331 ("The problem with model statutes is that, because criminal HIV exposure statutes are by nature political, states not in agreement with the sympathies of the author of the model statute are left without guidance; yet to provide separate models of statutes suitable for the needs and goals of the various states in the U.S. would be an arduous task.").

[170] HIV-exposure charges could also be brought under reckless endangerment, assault, bioterrorism, homicide, and attempted homicide statutes. For an overview of traditional crimes that might apply to HIV exposure, see Sullivan & Field, supra note 29, at 162-69, and McGuire, supra note 29, at 1795-1802.

[171] See, e.g., Minahan, supra note 147, at 106; Jaclyn Schmitt Hermes, Note, The Criminal Transmission of HIV: A Proposal to Eliminate Iowa's Statute, 6 J. Gender Race & Just. 473, 489 (2002); McArthur, supra note 21; Rebecca Ruby, Note, Apprehending the Weapon Within: The Case for Criminalizing the Intentional Transmission of HIV, 36 Am. Crim. L. Rev. 313, 325 (1999).

[172] See Klemm, supra note 11, at 521.

[173] See McArthur, supra note 21, at 741.

[174] Klemm, supra note 11, at 521.

[175] Many commentators agree. See, e.g., Hermann, supra note 79, at 378; Klemm, supra note 11, at 521-22; Jodi Mosiello, Note, Why the Intentional Sexual Transmission of Human Immunodeficiency Virus (HIV) Should Be Criminalized Through the Use of Specific HIV Criminal Statutes, 15 N.Y.L. Sch. J. Hum. Rts. 595, 610 (1999).

[176] See, e.g., State v. Price, 834 N.E.2d 847, 849 (Ohio Ct. App. 2005) (affirming the HIV-positive appellant's

conviction for felonious assault because "his saliva was a deadly weapon capable of inflicting physical harm to another").

177 Report, supra note 12.

178 For a general discussion of this debate, see Pierre Schlag, Rules and Standards, 33 UCLA L. Rev. 379, 383-90 (1985), and Cass R. Sunstein, Problems with Rules, 83 Calif. L. Rev. 953, 969-96 (1995). For a specific discussion of the rules-standards debate as applied to HIV-exposure laws, see Kaplan, supra note 29, at 1553-59.

179 Cf. supra note 87.

180 See supra notes 121-22 and accompanying text (discussing Illinois's vague definition of "intimate contact").

181 For example, behaviors on this list might include having unprotected vaginal or anal sex, as well as having an HIV-positive individual as the receptive partner during unprotected oral sex. California has taken this approach by limiting its definition of prohibited sexual activity to "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." Cal. Health & Safety Code § 120291(b)(1) (West 2012).

182 Behaviors on this list might include kissing, spitting, biting, masturbation, protected intercourse, using noncontaminated sex toys, and performing oral sex if one is HIV positive.

183 Kaplan, supra note 29, at 1555.

184 See id. at 1543; McArthur, supra note 21, at 737.

185 Sunset provisions are "clauses that cause legislation to expire by its own terms." Rebecca M. Kysar, Lasting Legislation, 159 U. Pa. L. Rev. 1007, 1009 n.4 (2011).

186 See Kaplan, supra note 29, at 1567-68. Professor Margo Kaplan cautions, however, that sunset provisions "have significant administrative costs and other detriments" and "may fail to solve the problem of politically popular but scientifically outdated offenses." Id. at 1568.

187 Cal. Health & Safety Code § 120291(b)(2) (West 2012) (defining unprotected sexual activity). Minnesota's HIV statute takes a similar approach by limiting the definition of sexual penetration to certain sexual acts "committed without the use of a latex or other effective barrier." Minn. Stat. Ann. §609.2241(1)(e) (West 2009).

188 Only five states have provisions related to condom use. See supra note 135 (discussing the statutes in Missouri, California, Minnesota, North Carolina, and North Dakota).

189 See supra note 137 and accompanying text.

190 North Dakota and North Carolina have taken this approach. See N.D. Cent. Code § 12.1-20-17(3) (2012); 10A N.C. Admin. Code 41A.0202 (2007).

191 North Dakota has taken this approach. See N.D. Cent. Code § 12.1-20-17(3) ("It is an affirmative defense to a

prosecution under this section that if the transfer was by sexual activity, the sexual activity took place between consenting adults after full disclosure of the risk of such activity and with the use of an appropriate prophylactic device." (emphasis added)).

192 See supra Part III.B.

193 See, e.g., Burris et al., supra note 114, at 505 (finding in an empirical study with a 490-person sample that "belief that the law requires disclosure or condom use ... did not predict actual sexual behavior among either the infected or the uninfected").

194 See Kaplan, supra note 29, at 1535-36.

195 See Michael L. Metzker et al., Molecular Evidence of HIV-1 Transmission in a Criminal Case, 99 PNAS 14,292 (2002). A confirmed relationship between two HIV strains, however, confirms only the transmission event, not the direction of transmission. See id. at 14,296. The testing also does not foreclose the possibility that additional individuals were "involved in a series of intermediate transmissions." Id. Incubation periods, during which the virus is not detectable, may also make this element of proof more difficult. See Closen, supra note 29, at 49 ("As a practical matter, due to the possibly very long incubation period for symptoms of HIV infection, many individuals will not be able to identify the time, place, and source of their HIV infection--let alone to prove it beyond a reasonable doubt.").

196 See supra notes 125-27 and accompanying text.

197 See Cynthia Ann Wicktom, Note, Focusing on the Offender's Forceful Conduct: A Proposal for the Redefinition of Rape Laws, 56 Geo. Wash. L. Rev. 399, 425-28 (1988).

198 See Stephen J. Schulhofer, Unwanted Sex: The Culture of Intimidation and the Failure of Law 22 (1998).

199 Id.

200 Kaplan, supra note 29, at 1561.

201 Id.

202 Id.

203 See id. at 1534 & n.114.

204 Id. at 1534 (emphasis added).

205 See Scott Burris & Edwin Cameron, The Case Against Criminalization of HIV Transmission, 300 JAMA 578, 579 (2008) ("[R]ational people operating with genuine autonomy should recognize exposure as a normal risk of sexual behavior.").

206 Grant, supra note 137, at 399.

[207] See supra note 194 and accompanying text.

[208] See Bragdon v. Abbott, 524 U.S. 624, 631 (1998); 28 C.F.R. § 36.104 (2012); Kaplan, supra note 29, at 1524-25.

[209] Kaplan, supra note 29, at 1524-25.

[210] These statutes criminalize exposure to other STIs. Most of these statutes were enacted before the discovery of HIV and have not been used to prosecute HIV exposure. See generally Ctr. for HIV Law & Policy, supra note 4, at 2 & n.5 (providing a brief overview of communicable disease control statutes).

[211] See, e.g., Ark. Code Ann. § 5-14-123 (2006); Fla. Stat. Ann. § 384.24(2) (West 2007).

[212] See, e.g., Ala. Code § 22-11A-21(c) (LexisNexis 2006); Cal. Health & Safety Code § 120600 (West 2012).

[213] See supra notes 50-56 and accompanying text.

[214] See Genital HPV Infection--Fact Sheet, Centers for Disease Control & Prevention (last updated Mar. 18, 2013), http:// www.cdc.gov/std/hpv/stdfact-hpv.htm.

[215] See Kaplan, supra note 29, at 1532-34.

[216] Virginia has taken this approach, making it a Class 6 felony for an HIV-positive individual to engage in certain sexual conduct "with the intent to transmit the infection to another person," Va. Code Ann. § 18.2-67.4:1(A) (2009), but making it a Class 1 misdemeanor for a person to engage in the same conduct with only the knowledge of her HIV status but absent the intent to transmit, see id. § 18.2-67.4:1(B). See also Ind. Code Ann. § 35-42-1-9 (West 2012) (classifying reckless exposure as a Class B misdemeanor and knowing or intentional exposure as a Class D felony).

[217] California has taken this approach. See Cal. Health & Safety Code § 120291 (West 2012). There has been only one recorded case of an individual being convicted under California's statute, and even then the conviction resulted from a plea. See 1 Ctr. for HIV Law & Policy, supra note 4, at 18; Tomoyo Shimura, A.V. Gangster Pleads Guilty to Spreading HIV Infection, Daily Press, Sept. 8, 2010, at B1.

[218] See supra notes 156-57 and accompanying text.

[219] See Kaplan, supra note 29, at 1545 & n.169.

[220] The Supreme Court of Kansas discussed these factors as possible circumstantial evidence to prove specific intent. See State v. Richardson, 209 P.3d 696, 704 (Kan. 2009).

[221] See supra note 93 and accompanying text.

[222] See supra notes 100-01 and accompanying text.

[223] Cf. Wolf & Vezina, supra note 29, at 859 ("The failure to account for safer sex prevention efforts suggests an underlying message that HIV-infected people should not engage in sexual relations.").

[224] Cf. Sullivan & Field, supra note 29, at 177 ("A flat ban on sex for AIDS carriers seems not only unrealistic but also inhumane.").