

**Interim-20-ID-05**

**Committee:** Infectious Disease

**Title:** CSTE recommendations for modernization of laws to prevent HIV criminalization

**I. Statement of the Problem:**

The *Ending the HIV Epidemic (EHE): A Plan for America*<sup>1</sup> initiative aims to reduce new HIV infections in the United States by 90% by 2030 through leveraging critical advances in HIV prevention, diagnosis, treatment and outbreak response. People with living with HIV (PLWH) and stakeholders continue to raise concerns about HIV criminalization as a potential barrier to achieving HIV prevention and care goals<sup>2</sup>. These laws may prevent public health agencies from responding effectively to the HIV epidemic by perpetuating stigma, racism, xenophobia, social and economic injustice, and reducing willingness for people to participate in HIV prevention, testing, and care.

HIV criminalization is defined as laws and policies that are used to criminalize the transmission of or exposure to HIV, or to enhance sentencing because a person has HIV. These laws and policies put PLWH potentially at risk for prosecution in all states, with the majority of states having HIV-specific laws in place.<sup>3</sup> However, state laws, and the application of these laws, vary widely. Most laws do not account for the actual scientifically-based level of risk engaged in or risk reduction measures undertaken by PLWH or persons exposed to HIV.<sup>3,4</sup> In some states, public health officials are required by law to share protected health information with law enforcement officials.

HIV criminalization has not been shown to be an effective public health intervention. There is no association between HIV infection diagnosis rates and the presence of state laws criminalizing HIV exposure.<sup>5</sup> Studies have suggested these laws are associated with decreased HIV testing and increased HIV prevalence.<sup>6,7</sup> Surveys among PLWH have not demonstrated that these laws have an effect on sexual practices and therefore, these laws do not serve as a deterrent for potential HIV exposure.<sup>8,9</sup> Given the punitive but ineffectual outcomes of these laws on PLWH, existing HIV-related laws must be eliminated.

**II. Statement of the desired action(s) to be taken:**

HIV criminalization laws and policies do not reflect the current science of HIV, but instead criminalize behaviors posing low or negligible risk for HIV transmission, stigmatize and discriminate against PLWH, and undermine national and local HIV prevention efforts. CSTE joins numerous other organizations<sup>10-16</sup> across the globe in strongly opposing any criminalization of HIV exposure or transmission and recommends that all states, U.S. territories, and local jurisdictions:

- 1) Eliminate HIV-specific statutes that criminalize HIV, including HIV-specific penalties under general statutes.
- 2) Eliminate prosecution of HIV under general statutes (non-HIV specific criminalization).
- 3) Change relevant state and local statutes to specifically prohibit the use of HIV-related, public health data for uses outside of public health purposes, including law enforcement, family law, immigration, civil suits, or other legal purposes.

Public health agencies are the central authorities of the nation's public health system and must actively inform public policy to ensure laws, regulations, and policies are data driven and scientifically sound. Local, state, and territorial public health officials can do this by engaging in the following activities.<sup>17-26</sup>

1. Investigate their city, county, and/or state's laws, regulations, and policies on HIV criminalization and data protection.
2. Assess the disproportionate impact of HIV criminalization laws (in their city, county, and state) on racial, ethnic, immigrant, LGBTQ and other priority populations (now referred to collectively as priority populations).<sup>27</sup>

3. Engage with and educate public health legal counsel to assure they are up to date on surveillance technology and science of HIV transmission.
4. Review internal legal counsel and health department policies and practices with regard to public health data release for law enforcement purposes and prohibit or significantly limit data release or strengthen data protections when data must be released.
5. Provide unequivocal public health leadership, education, support and information to elected state and local officials, prosecutors, and law enforcement on the relative risks of transmission and the dangers of a punitive response to HIV exposure on our ability to respond to the epidemic.
6. Provide information at legislative or governmental hearings emphasizing data-driven and scientifically sound public health arguments against HIV criminalization.
7. Engage community stakeholders most affected by the epidemic on the impact of HIV criminalization on their lives. Invite them to partner with their relevant public health department to eliminate these laws.
8. Ensure states and local jurisdictions assess the impact of HIV criminalization and address action steps for HIV decriminalization in their EHE initiative implementation plans and the disproportionate impact on priority populations.
9. Identify and share best practices with elected state and local officials, law enforcement and community stakeholders related to successes in changing laws and policies to prevent HIV criminalization.
10. Provide information to the media on advances in HIV treatment and prevention and the detrimental impact of HIV criminalization and prosecution on public health efforts.

### **III. Public Health Impact:**

Preventing HIV criminalization will diminish the burden that has been placed on priority populations<sup>28-31</sup> and strengthen public health interventions. HIV decriminalization has the potential to engage more individuals in HIV testing and care, leading to earlier antiretroviral treatment (ART) initiation, increased viral suppression, and decreased transmission. Furthermore, prevention activities can be strengthened as more individuals become aware of their HIV status and potential risks for acquiring HIV.

#### **1. Increase HIV testing.**

Studies suggest that HIV criminalization laws deter participation in HIV testing.<sup>6-9,32,33</sup> Deterrence to HIV testing propagates HIV transmission and results in missed opportunities for HIV care and early ART initiation specifically in priority populations. Thirty-eight percent of new HIV transmissions are attributed to PLWH who are unaware of their status; therefore, HIV testing is essential to increasing awareness among PLWH.<sup>34</sup>

#### **2. Decrease stigma and discrimination related to HIV.**

Given the heightened community concerns regarding law enforcement actions in minority communities, it is critical that public health activities are decoupled from law enforcement. HIV criminalization perpetuates stigma and discrimination, which are significant barriers to EHE, thereby fueling the epidemic.<sup>35,36</sup> Eliminating HIV criminalization laws will reduce stigma and may help meet EHE targets.

#### **3. Remove a disincentive to participation in public health efforts (i.e., EHE Pillars: Prevent, Diagnose, Treat, and Respond)**

Trust is the cornerstone of public health, yet communities of color have a long history of systemic and institutional racism that has eroded trust in public health. Public health officials and community members have raised concerns that routinely-collected public health data can be misused for HIV criminalization and contribute to community opposition to partner services and cluster response.<sup>2</sup> Removing HIV criminalization laws and securing HIV data protections will help to rebuild trust in public health and engage communities of color in critical public health services.

### **IV. Revision History**

Not applicable.

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**Definitions:**

**Cluster Response** – the identification of growing clusters of HIV transmission and the actions taken to prevent further transmission within the cluster and its associated risk network are detected.

**Early ART Initiation** – the action of beginning an antiretroviral therapy (ART) on the day of or soon after HIV diagnosis, regardless of CD4 count, in order to maintain immune function and reduce HIV viral load, preventing further transmission

**Ending the HIV Epidemic (EHE): A Plan for America** – an initiative launched by the U.S. Department of Health and Human Services (HHS) has launched that aims to reduce new HIV infections in the U.S. by 90% by the year 2030 through four identified pillars: Prevent, Diagnosis, Treatment, Response.

**HIV Criminalization** – Inclusive term that refers to state and local laws, policies, and statutes that are used to criminalize the transmission of, or exposure to, HIV or those statutes that enhance sentencing as a result of a person's HIV status.

**HIV Discrimination** – the unfair and unjust treatment of someone based on their real or perceived HIV status

**HIV Partner Services** – a function of local and state health departments to help identify and locate sexual or injection partners to inform them of their risk for HIV and to provide them with testing, counseling, and referrals for other support services

**HIV Stigma** – negative beliefs, feelings, and attitudes towards people living with HIV, their families, service providers, and members of groups that have been heavily impacted by HIV

**HIV Transmission Cluster** – a group of HIV-infected persons (with diagnosed or undiagnosed HIV) who are connected by HIV transmission and can represent recent and ongoing HIV transmission in a population where prevention efforts are needed

**PLWH** – Acronym representing a person(s) living with HIV

**Viral Suppression** – the state in which antiretroviral therapy (ART) reduces a person's viral load (HIV RNA) to an undetectable level, generally below 200 copies/mL.



## **Summary of current criminalization laws, other laws used to prosecute HIV exposures, and sentence enhancement for HIV exposure.**

As of 2019, 34 states have laws specifically criminalizing the transmission of or exposure to HIV, however, there are laws and policies in all 50 states and Washington, DC that put PLWH at risk for prosecution (1). The actual laws and their application vary widely. Most laws do not account for the actual scientifically-based level of risk engaged in or risk reduction measures undertaken. (1, 2)

Public health already uses many strategies to decrease community transmission, including testing, linkages to care, provision of anti-HIV medications, harm reduction and syringe exchange programs, and social services, including housing and employment. Public Health authorities can already use state and local law to coerce or isolate individuals who purposely or maliciously transmit disease, including HIV, with the intent to harm (3,4,5). While state and local health laws vary, public health authorities can seek assistance from law enforcement officers to enforce public health orders, including cease and desist, isolation and detainment (6).

An additional use of laws criminalizing HIV is the use of personal health information as leverage in plea negotiation or to enhance sentences. All phases of prosecution from arrest to sentencing are influenced by the fear and stigma associated with HIV infection (5,7).

Laws used in the USA to prosecute people with HIV include (1,5,6,8):

- Communicable disease or contagious disease statutes
- Reckless endangerment, assault, bioterrorism, homicide or attempted homicide
- Civil commitment laws may also be used to confine a person to a medical or mental health facility, register as sexually violent offender or be designated as a person who suffers from a condition affecting emotional or volitional capacity such that they pose a menace to the health and safety of others.

The CDC tracks additional information about laws related to HIV as of 2019 (1):

- 21 states require disclosure of HIV status to sexual partners
- 12 states require disclosure to needle-sharing partners
- 17 states have HIV-specific laws related to blood, tissue and organ donation
- 11 states have HIV-specific laws related to prostitution and solicitation
- Several states criminalize one or more behaviors that pose a low or negligible risk for HIV transmission including:
  - 5 states have HIV-specific laws related to sex objects
  - 13 states have HIV-related laws related to oral sex
  - 10 states have HIV-specific laws related to biting, spitting, or throwing urine/feces
- At least 25 states have maximum sentences of 5 or more years

The Center for HIV Law and Policy published a timeline of State reforms and repeals of HIV criminal laws since 1994 (6). States making an effort to modernize non-HIV specific laws can learn from the experience of past attempts to do so in seven states and in other states or national efforts to modernize laws involving HIV (5,6, 8).

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Vol 2: [http://www.hivlawandpolicy.org/sites/default/files/A%20Legal%20Toolkit\\_0.pdf](http://www.hivlawandpolicy.org/sites/default/files/A%20Legal%20Toolkit_0.pdf)  
Vol 3: <https://hivlawcommission.org/wp-content/uploads/2017/06/Ending-and-Defending-Against-HIV-Criminalization-A-Manual-for-Advocates.pdf>

## Summary of the science of HIV transmission in the context of criminalization

Data on HIV transmission shows us that this virus is not easily transmitted from one person to another. The risk of acquiring HIV depends on the type of exposure (i.e. sharing needles or having sex without a condom). The table below indicates the estimated risk of transmission per 10,000 exposures for various types of exposures.<sup>1-3</sup>

### Estimated Per-Act Probability of Acquiring HIV from an Infected Source, by Exposure Act\*

Type of Exposure	Risk per 10,000 Exposures
<b>Parenteral</b>	
Blood Transfusion	9,250
Needle-Sharing During Injection Drug Use	63
Percutaneous (Needle-Stick)	23
<b>Sexual</b>	
Receptive Anal Intercourse	138
Insertive Anal Intercourse	11
Receptive Penile-Vaginal Intercourse	8
Insertive Penile-Vaginal Intercourse	4
Receptive Oral Intercourse	Low
Insertive Oral Intercourse	Low
<b>Other<sup>^</sup></b>	
Biting	Negligible
Spitting	Negligible
Throwing Body Fluids (Including Semen or Saliva)	Negligible
Sharing Sex Toys	Negligible

\* Factors that may increase the risk of HIV transmission include sexually transmitted diseases, acute and late-stage HIV infection, and high viral load. Factors that may decrease the risk include condom use, male circumcision, antiretroviral treatment, and pre-exposure prophylaxis. None of these factors are accounted for in the estimates presented in the table.

<sup>^</sup> HIV transmission through these exposure routes is technically possible but unlikely and not well documented.

#### Source:

- Patel P, Borkowf CB, Brooks JT, Et al. Estimating per-act HIV transmission risk: a systematic review. *AIDS*. 2014. doi: 10.1097/QAD.0000000000000298.
- Pretty LA, Anderson GS, Sweet DJ. Human bites and the risk of human immunodeficiency virus transmission. *Am J Forensic Med Pathol* 1999;20(3):232-239.

For all exposures except parenteral such as a blood transfusion, the risk of acquiring HIV is low with transmission probability far below 1% and majority of circumstances the probability is negligible or poses no risk.<sup>4</sup>

There are also several factors that further influence the risk of HIV transmission. The most important of these is HIV viral suppression where the HIV viral load is low or undetectable. Numerous studies involving both heterosexual and male couples with different HIV serostatus have not identified any HIV transmissions when the HIV infected partner was undetectable.<sup>5-8</sup> The Centers for Disease Control has issued a statement on this indicated that PLWH who take antiretroviral therapy, achieve and maintain an undetectable viral load have essentially no risk of transmitting HIV to their sexual partners.<sup>9</sup>

## Risk of HIV Transmission With Undetectable Viral Load by Transmission Category

Transmission Category	Risk for People Who Keep an Undetectable Viral Load
Sex (oral, anal, or vaginal)	Effectively no risk
Pregnancy, labor, and delivery	1% or less <sup>†</sup>
Sharing syringes or other drug injection equipment	Unknown, but likely reduced risk
Breastfeeding	Substantially reduces, but does not eliminate risk. Current recommendation in the United States is that mothers with HIV should <i>not</i> breastfeed their infants.

<sup>†</sup> The risk of transmitting HIV to the baby can be 1% or less if the mother takes HIV medicine daily as prescribed throughout pregnancy, labor, and delivery and gives HIV medicine to her baby for 4-6 weeks after giving birth.

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## **Summary of who is being impacted by HIV prosecution (who is prosecuted/convicted for HIV criminalization - minorities, immigrants, women)**

Disparities in criminal prosecution related to an individual's positive HIV status have been observed among several racial, ethnic, gender, geographic, and socially unfavored groups, such as sex workers, as a result of HIV criminalization laws in the United States. While rates of contacts with the criminal justice system and criminal convictions vary across populations by state, Black men, Black women, individuals engaged in sex work activities, and non-citizen immigrant populations make up the greatest proportions of arrests and subsequent prosecutions. Criminal arrest records and sentencing information related to HIV criminalization were analyzed for states with direct and non-direct HIV laws such as in California, Florida, and Georgia.

Data from California's Criminal Offender Record Information (CORI) showed a total of 800 individuals with HIV-related criminal encounters from 1988 to June 2014 with disproportionate impact for marginalized groups including Blacks, Latinos, women, and non-citizen immigrants. While making up about half (51%) of the PLWH in California, Black and Latinos represented 67% of the people having contact with the criminal justice system due to their positive HIV status. More specifically, women made up only 13% of the PLWH but 43% of those that had HIV-related criminal encounters. In comparison, White men made up 40% of the PLWH but only 16% of those with criminal contact based on their positive status. While 95% of all encounters included charges related to sex work, White men were less likely to be charged, especially related to sex work while HIV positive, and had a higher likelihood of being released without any charges compared to all other racial/gender groups (1). Foreign-born individuals made up 15% of all HIV-related criminal encounters in California with 88% of individuals being identified as men at birth. Immigration data for those with criminal charges related to their HIV status showed that 25% of individuals with histories of immigration proceedings experienced such following their encounter with the criminal justice system related to their HIV status (2).

Like California, criminal history record information (CHRI) related to HIV specific criminal encounters in Florida from 1986 to 2017 showed racial, ethnic, gender, geographic, and sex work related disparities. Although HIV prevalence was highest in large urban areas of the state, the proportion of HIV related criminal contacts were highest in counties with lower prevalence. Of the 847 noted criminal encounters, over 40% of the arrests were among Black individuals. While women made up only 27% of the PLWH in Florida, they represented over half of the number of individuals having HIV-related contact with the criminal justice system. When looking at arrest and conviction records related to HIV status among women, White women were more likely to be arrested, and Black women were more likely to be charged and convicted related to sex work offenses. Convictions for HIV related offenses showed huge disproportionality with highest rates in Black women (60%), Black men (42%), White women (3%), and lastly, White men (18%). Black men were more likely to be convicted compared to White men and White women in all HIV related crimes other than sex work (3).

Criminal encounters related to HIV status were reviewed for the state of Georgia using criminal history record information (CHRI). Like California and Florida, disproportionate rates of HIV-related criminality were observed for individuals based on race, ethnicity, gender at birth, and sex worker status at the time of encounter. Of the 571 encounters from 1988 through 2017, the highest proportions of arrests were noted in the counties with the lowest prevalence rates of HIV, or in the more rural sections of the state. When looking at race, Blacks accounted for 63% of the total number of people arrested, and Black men (46%) and Black women (16%) were more likely to be arrested than White men (26%) and White women (11%). However, like other states, White women were most affected by arrests while making up the smallest proportion of PLWH in Georgia (3%) most likely related to sex work or suspected sex work being involved during the criminal encounter. Data from Georgia shows that sex work offenses lead to higher rates of convictions overall, and Black men were two times more likely to be convicted of HIV related offenses than White men (16% and 9%, respectively) (4).

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## Summary of harms to public health

Criminalization of HIV infection has not been shown to be an effective public health intervention. There is no association between HIV infection diagnosis rates and the presence of state laws criminalizing HIV exposure<sup>1</sup> and, when adjusted to estimated HIV prevalence, are associated with decreased HIV testing and increased HIV prevalence.<sup>2</sup> Surveys have shown HIV criminalization laws effects on sexual practices of persons living with HIV infection (PLWH) to be mixed,<sup>3</sup> and PLWH are already more likely to take up risk reduction behavior and engage in medical care which reduces further transmission by suppressing viral load.<sup>4,5</sup> Most surveyed persons who were HIV negative or didn't know their HIV status did not change their testing behaviors in the environment of HIV exposure criminalization, but those who did had more reported high risk behavior and were less likely to seek STD testing.<sup>6</sup> Additionally, those persons pursued HIV testing in a way that decreased assistance with entry to HIV medical care and public health follow-up of contacts,<sup>7,8,9</sup> both of which are absolutely vital tools and for protecting public health.

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<sup>3</sup> O'Byrne P, Bryan A, Roy M. HIV criminal prosecutions and public health: an examination of the empirical research. *Med Humanit* 2013; 0:1-6.

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<sup>6</sup> Dodds C, Bourne A, Weait M. Responses to criminal prosecutions for HIV transmission among gay men with HIV in England & Wales. *Repro Health Matters* 2009;17(34):135–45.

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<sup>9</sup> O'Byrne P, Bryan A, Roy M. Sexual practices and STI/HIV testing among gay, bisexual, and other men who have sex with men in Ottawa, Canada: examining nondisclosure prosecutions and HIV prevention. *Crit Public Health* 2013;23 (2):225–36.

## Summary of concerns related to molecular HIV surveillance (MHS)

States and Jurisdictions have been collecting HIV DNA or RNA sequences, also known as genotypes, for many years as part of routine HIV surveillance activities. These sequences have been incorporated into data into our surveillance database, eHARS (Enhanced HIV/AIDS Reporting System). HIV genotypes are an intermediate result of drug resistance testing performed by medical providers during routine HIV care. In 2015, CDC combined HIV surveillance data and phylodynamic analysis to identify networks of transmission. This analysis is similar to foodborne outbreak investigation and tuberculosis cluster investigation techniques that have been employed by public health professionals for over 20 years. To end the HIV epidemic, it is critical to deliver timely, appropriate care and prevention services wherever HIV is spreading. Using data to identify and respond quickly to potential HIV outbreaks is a core pillar of the Ending the HIV Epidemic initiative (Respond). Analyzing HIV molecular data generated for drug resistance testing helps public health agencies monitor drug resistance in the population, better understand transmission patterns, and detect and respond to clusters and outbreaks. Using this rich data source, we are able to identify groups of persons who are in networks with recent and rapid ongoing HIV transmission. Clusters identified using CDC methods have transmission rates nearly 10 times the rate of average HIV transmission in the United States.<sup>1</sup> Investigation of these clusters have allowed HIV surveillance and prevention programs to target limited funding and staff to areas where they will make the most impact, and stop onward transmission.

Public health professionals and community members alike have raised concerns that this information could be misconstrued or misused in criminal or civil cases to demonstrate direct links between 2 or more people. Molecular analysis examines the genetics of the virus – not the person – and doesn't identify who infected whom. Because HIV evolves quickly, similar viral strains signal that HIV transmission is occurring rapidly within a common network.<sup>1</sup> If used for legal purposes, sequence data are only appropriate to determine that two cases are not related. However, these limitations may not be understood by judges and juries.<sup>1</sup>

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- 1) CDC (2018). Detecting and responding to HIV clusters: A guide for health departments, 2018 (Preliminary). *HIV Surveillance Guide 2018*; 2.



## Summary of the impact of repealing HIV criminalization in states that have repealed laws

Since 1994, there have been a total of 7 states that have made significant changes to their HIV criminalization laws by either repealing existing laws or making reforms to the current legislation. The first major change to HIV criminalization laws began in Texas in 1994. Prior to 1994, Texas had an HIV transmission statute that charged PLWH with felonies for transferring bodily fluids (including saliva) if there was intent to transmit. Fortunately, this criminal statute was repealed, however this didn't stop prosecutions of PLWH from happening. Instead, PLWH started to become prosecuted for HIV exposure under general criminal laws, including attempted murder and aggravated assault. In some instances, Texas courts decided that the seminal fluid of a PLWH constituted a deadly weapon for the purpose of aggravated assault and lead to prison convictions of 70+ years. Repeal of an-HIV-specific criminalization statute in Texas was not substantial enough to end criminalization of PLWH, and may have even resulted in more extreme felony charges when bodily fluids (even despite low transmission risk) were used as examples of deadly weapons.

In Illinois, an HIV criminal transmission law was put into place in 1989. However, in 2012 Senate Bill 3637 was passed to minimize the previous legislations' harm as much as possible. Under the new reformed bill, in order to prosecute an HIV-related crime a person must have engaged in anal/vaginal intercourse and must have had an intent to transmit HIV. Under the new reformed bill, reported condom use and disclosure of HIV status could have been used as a defense for the prosecution, however other forms of prevention (including HIV viral suppression/adherence to ARVS) were not included in this prosecution exemption. Despite these reform changes, intercourse without HIV status disclosure or without condom use, was still considered a felony punishable of up to 7 years of prison (even without HIV transmission occurring). As a result, PLWH have still been prosecuted under the law. For example, in 2014 an Illinois man was accused of criminal transmission of HIV (even though the person he engaged with tested negative). The defendant was able to have charges dropped to a misdemeanor because the intent to transmit wasn't viable, but he was still was on court supervision for 18 months and needed to perform 150 hours of community service. Overall, the reformed bill demonstrates improvements and compromise, however problematic sections, including the subjective language related to HIV disclosure and condom use, and the worrisome nature of prosecuting individuals without HIV transmission, remain.

Iowa's HIV criminalization law (Iowa Code 709C) originally passed in 1998 and made it a felony, punishable up to 25 years in prison, for PLWH to expose the body of one person to a bodily fluid of another person in a manner that could result in transmission. Under the original law, people could be found guilty of a felony even if a condom was used and no transmission occurred, and sentences included listing on the state's sex offender registry. In 2014, Iowa rewrote its law by: 1) Strengthening the prior law's standards for determining intent to transmit; 2) Requiring that there be substantial risk of transmission; 3) Removing sex offender registration requirements; 4) Adding a prosecution defense if person took practical measure to prevent transmission (i.e., good faith compliance with treatment prescribed by a medical provider and 5) Adding other communicable diseases, including TB, hepatitis, and meningococcal disease to the statute. Despite improvements, the reformed law had its shortcomings. Exposure with intent to transmit, with or without transmission, were both still considered felonies. Also, the creation of new felony offenses for other stigmatized conditions had the potential to disproportionately impact marginalized communities, including immigrants. Intentional transmission continued to be classified as a Class B felony that is punishable with a penalty of up to 25 years imprisonment. Given that PLWH on ART treatment have nearly a normal life expectancy, this punishment is out of proportion to the outcome of the crime. Intent to transmit that does not result in actual transmission is still punishable at a Class D felony that is punishable with up to 5 years imprisonment.

Signed into law in 2017 and effective January 1, 2018, Senate Bill 239 in California was the most expansive HIV criminalization reform bill in the United States, to date. Prior to the passing of SB 239, between 1988 to mid-2014, approximately 800 people had come into contact with the California criminal justice system either under an HIV related law or under a misdemeanor exposure law related to a person's HIV status. In California, 95% of these cases affected people engaged or believed to be engaged in sex work. The reform bill replaced the pre-existing HIV felony exposure laws to a misdemeanor and made communicable disease statutes non-specific to HIV. Under the reformed law

(excluding cases of sexual assault), imprisonment was restricted to 6 months for individuals with an infectious and communicable disease who engaged in conduct that posed a substantial risk of transmission, had knowledge of their communicable disease, had intent to transmit without the knowledge of the exposure, and actually transmitted the disease to the exposures. In cases related to sex workers living with HIV, SB 239 eliminated the felony penalty enhancement for engaging in commercial sexual activity while living with HIV, and also eliminated required HIV testing for people engaging in sex work, thus making the HIV criminalization laws the same regardless of money being exchanged.

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