Supreme Court of Ohio Clerk of Court - Filed December 27, 2016 - Case No. 2016-0903

IN THE SUPREME COURT OF OHIO

STATE OF OHIO,	*	Supreme Court
	*	Case No. 2016-0903
Appellee,	*	
	*	On Appeal from the
	*	Hamilton County Court of
vs.	*	Appeals, First Appellate
	*	District
ORLANDO BATISTA,	*	
	*	Court of Appeals
Appellant.	*	Case No. 150341

BRIEF OF *AMICI CURIAE* THE CENTER FOR HIV LAW AND POLICY, THE AMERICAN ACADEMY OF HIV MEDICINE, GLBTQ LEGAL ADVOCATES & DEFENDERS, GLMA: HEALTH PROFESSIONALS ADVANCING LGBT EQUALITY, HUMAN RIGHTS CAMPAIGN, THE NATIONAL ASSOCIATION OF CRIMINAL DEFENSE LAWYERS, THE NATIONAL CENTER FOR LESBIAN RIGHTS, THE OFFICE OF THE OHIO PUBLIC DEFENDER, AND TREATMENT ACTION GROUP ON BEHALF OF APPELLANT ORLANDO BATISTA

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Grutter v. Bollinger,
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Hargrave v. Vermont,
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Harris v. Thigpen,
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Kramer v. Union Free Sch. Dist. No. 15,
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Massachusetts Bd. of Retirement v. Murgia,
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Mussivand v. David,
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Nordlinger v. Harn,
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Pa. Dep't. of Corrs. v. Yeskey,
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Peck v. Clayton County,
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Pers. Adm'r of Massachusetts v. Feeney,
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Pickaway Cty. Skilled Gaming, L.L.C. v. Cordary,
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Randolph v. Rogers,
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Romer v. Evans,
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San Antonio Indep. Sch. Dist. v. Rodriguez,
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Sch. Bd. v. Arline,
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Shapiro v. Thompson,
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State v. Batista,
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State v. Klembus,
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State v. Noling,
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State v. Thompson,
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State v. Williams,
88 Ohio St.3d 513 (2000) 13, 17

U.S. Conf. of Mayors, *HIV Discrimination and Criminalization*
(2013), *available at*
http://www.usmayors.org/resolutions/81st_Conference/csj11.asp. 11

U.S. v. U.S. Gypsum Co.,
438 U.S. 422 (1978)...22

Vance v. Bradley,
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Whalen v. Roe,
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Wolfe v. Ohio Dep't. of Rehab. & Corr.,
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42 U.S.C. § 12132 35

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Ohio Rev. Code Ann. § 2901.22(D) 22

Ohio Rev. Code Ann. § 2903.11(B) .... *passim*

Ohio Rev. Code Ann. § 2903.11(E)(4) 16

Ohio Rev. Code Ann. § 2907.01(A) 16

Ohio Rev. Code. Ann. § 2929.14 16

Ohio Rev. Code Ann. § 2929.21 17

Ohio Rev. Code Ann. § 3701.81 17

Other Authorities

Alison J. Rodger, *et al.*, *Mortality in Well Controlled HIV in the Continuous Antiretroviral Therapy Arms of the SMART and SPRIT Trials Compared with the General Population*, 27 AIDS 973 (2013) 8

Alison J. Rodger, *et al.*, *Sexual Activity without Condoms and Risk of HIV Transmission in Serodifferent Couples When the HIV-Positive Partner Is Using Suppressive Antiretroviral Therapy,* 316 J. Am. Med. Assn. 171 (2016) 20

Alison Rodger, *et al.*, *HIV Transmission Risk Through Condomless Sex If the HIV Positive Partner Is on Suppressive ART: PARTNER Study*, Presentation, 21st Conference on Retroviruses and Opportunistic Infections (2014), *presentation slides available at* http://www.chip.dk/portals/0/files/CROI_2014_PARTNER_slides.pdf 7

Am. Acad. of HIV Med., *Policy Position Statement on HIV Criminalization* (2015), *available at* http://www.aahivm.org/Upload_Module/upload/Advocacy/AAHIVM%20-%20PolicyPlatform%20-%20Final%202015.pdf. 11

Am. & HIV Med. Assoc., *Position on the Criminalization of HIV, Sexually Transmitted Infections and Other Communicable Diseases* (2015), *available at* http://www.hivma.org/uploadedFiles/HIVMA/Policy_and_Advocacy/HIVMA-IDSA-Communicable%20Disease%20Criminalization%20Statement%20Final.pdf........................10

Am. Med. Assoc., *H-20.914 Discrimination and Criminalization Based on HIV Seropositivity* (2014), *available at* http://hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/AMA%20Resolution.pdf 10

Amer. Psych. Assoc., *Resolution Opposing HIV Criminalization* (2016), *available at* http://www.apa.org/ab out/policy/hiv-criminalization.aspx. 11

Amie L. Meditz, *et al.*, *Sex, Race, and Geographic Region Influence Clinical Outcomes Following Primary HIV-1 Infection*, 203 J. Infectious Diseases 442 (2011) 30

Amira Hasenbush & Brian Zanoni, *HIV Criminalization in California: Penal Implications for People Living With HIV*, Williams Institute at UCLA Law (December 2015), *available at* http://williamsinstitute.law.ucla.edu/wp-content/uploads/HIVCriminalization.EvaluationofTransmissionRisk.2016.pdf 9

Angelo A. Alonzo & Nancy R. Reynolds, *Stigma, HIV and AIDS: An Exploration and Elaboration of a Stigma Trajectory*, in Medical Sociology, Vol. 3: Coping with Chronic Illness and Disease (Graham Scrambler ed. 2005) .... *passim*

Assoc. of Nurses in AIDS Care, *Position Statement: HIV Criminalization Laws and Policies Promote Discrimination and Must Be Reformed* (2014), *available at* http://www.nursesinaidscare.org/files/public/ANAC_PS_Criminalization_December12014.pdf 11

Brad Barber & Bronwen Lichtenstein, *Support for HIV Testing and HIV Criminalization Among Offenders Under Community Supervision*, 33 Research in the Sociology of Health Care 253 (2015) .... *passim*

Brook Kelly, *The Modern HIV/AIDS Epidemic*, 41 U. Balt. L. Rev. 355 (2012) 30, 31

Carol Galletly, *et al.*, *A Quantitative Study of Michigan's Criminal HIV Exposure Law*, 24 AIDS Care 174 (2012) 23

CDC, *Basic TB Facts* (2016), *available at* http://www.cdc.gov/tb/topic/basics/default.html 32

CDC, *Communities in Crisis: Is There a Generalized HIV Epidemic in Impoverished Urban Areas of the United States?* (2016), *available at* http://www.cdc.gov/hiv/group/poverty.html 30

CDC, *Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV* (2016), *available at* http://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html 19

CDC, *Genital HPV Infection - Fact Sheet* (2016), *available at* http://www.cdc.gov/std/hpv/stdfact-hpv.htm..........32

CDC, *HIV Among African American Gay and Bisexual Men* (2016), *available at* http://www.cdc.gov/hiv/group/msm/bmsm/index.html 9

CDC, *HIV Among African Americans* (2016), *available at* http://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html..........30

CDC, *HIV Among Pregnant Women, Infants, and Children*, *available at* http://www.cdc.gov/hiv/group/gender/pregnantwomen/index.html;..........39

CDC, *HIV in the United States: At a Glance* (2016), *available at* http://www.cdc.gov/hiv/statistics/overview/ataglance.html 33

CDC, *HIV Risk Reduction Tool*, (2016) *available* at http://wwwn.cdc.gov/hivrisk/transmit/activities/..........6

CDC, *Ohio – 2015 State Health Profile* (2016), *available at* https://www.cdc.gov/nchhstp/stateprofiles/pdf/ohio_profile.pdf 23

CDC, *Prevention Strategies for Individuals with HIV*, The Serostatus Approach (2001), *available at* http://www.cdc.gov/hiv/research/serostatusapproach/strategies.html 25

Cohen M. *et al.*, *Prevention of HIV-1 Infection with Early Antiretroviral Therapy*, 365 New England J. Med. 493 (2011) 20, 21

Dawn Smith *et al.*, *Condom Effectiveness for HIV Prevention by Consistency of Use Among Men Who Have Sex with Men in the United States*, 68 J. AIDS 337 (2015)..........7

Felorencia Pereya, *et. al., Genetic And Immunologic Heterogeneity Among Persons Who Control HIV Infection In The Absence Of Therapy*, 197 J. Infect. Dis. 563 (2008) 19

Gregg Gonsalves, *et al.*, *Panic, Paranoia, and Public Health — The AIDS Epidemic's Lessons for Ebola*, 371 New England J. Med. 2348 (2014) 5

Harvard Law Review, "Chapter Four: Animus & Sexual Regulation," 127 Harv. L. Rev. 1767 (2014) 5, 26, 28, 29

Hasina Samji, *et al.*, *Closing the Gap: Increases in Life Expectancy Among Treated Individuals in the United States and Canada*, 8 PLoS One 1 (2013), *available at* http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0081355. 8

J. Lerhman, *et al.*, *Prevalence and Public Health Implications of State Laws that Criminalize Potential HIV Exposure in the United States*, 18 AIDS and Behav 997 (2014) 18

K. Owusu-Edusei, *et. al., The Estimated Direct Medical Cost Of Selected Sexually Transmitted Infections In The United States, 2008,* 40 Sex. Trans. Dis. 197 (2013) 32

Karen R. Davis and Susan C. Weller, *The Effectiveness of Condoms in Reducing Heterosexual Transmission of HIV*, 31 Family Planning Perspectives 272 (1999) 7

Kathleen M. Sullivan & Martha A. Field, *Aids and the Coercive Power of the State*, 23 Harv. C.R.-C.L. L. Rev. 139 (1988) 6

Kim Buchanan, *When Is HIV a Crime? Sexuality, Gender, and Consent*, 99 Minn. L. Rev. 1231 (2015) .... *passim*

Larry Gostin, *The Politics of AIDS: Compulsory State Powers, Public Health, and Civil Liberties*, 49 Ohio St. L. J. 1017 (1989) 5

Mark DeMarino, "A Crime Not to Tell: HIV Laws Debated in Wake of High-Profile Arrest," *Eye on Ohio* (Dec. 26, 2013), *available at* http://eyeonohio.org/a-crime-not-to-tell-hiv-laws-debated-in-wake-of-high-profile-arrest/ 6

Nat'l Alliance of State and Terr. AIDS Dirs., *National HIV Strategy Imperative: Fighting Stigma and Discrimination by Repealing HIV-Specific Criminal Statutes* (2011), *available at* https://www.nastad.org/sites/default/files/114641_2011311_NASTAD-Statement-on-Criminalization-Final.pdf 10

Nat'l. Assoc. of Cty. & City Health Officials, *State of Policy: Opposing Stigma and Discrimination against Persons with Communicable Diseases* (2013), *available at* http://www.naccho.org/uploads/downloadable-resources/Policy-and-Advocacy/13-11-Opposing-Stigma-and-Discrimination-against-Persons-with-Communicable-Diseases-2.pdf. 11

Nat'l Inst. on Drug Abuse, *HIV/AIDS and Drug Abuse: Intertwined Epidemics* (2012), *available at* https:/www.drugabuse.gov/publications/drugfacts/hivaids-drug-abuse-intertwined-epidemics 5

Norman L. Reimer, *Inside NACDL: A Lamentable Example of Overcriminalization: HIV Criminalization*, 37 Champion 7 (December 2013) 34

Ohio Dep't. of Health, *Diagnosis of HIV and/or AIDS Reported in Ohio*, *available at* https://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/health%20statistics%20-%20disease%20-%20hiv-aids/WebTables12.pdf 24

Ohio Dep't. of Health, *History of Ohio's HIV/AIDS Epidemic, 1981-2010* (2016), *available at* https://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/health%20statistics%20-%20disease%20-%20hiv-aids/12OhioChart.pd 24

Patrick O'Byrne, *et al.*, *Nondisclosure Prosecutions and HIV Prevention: Results from an Ottawa-Based Gay Men's Sex Survey*, 24 J. Nurses Assn. AIDS Care 81 (2013) 23

Perinatal Transmission, *Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States*, *available at* https://aidsinfo.nih.gov/contentfiles/lvguidelines/perinatalgl.pdf (last updated Aug. 6, 2015) 39

President's Advisory Council on AIDS, *Resolution on Ending Federal and State HIV-Specific Criminal Laws, Prosecutions, and Civil Commitments* (2013), *available at* http://hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/PACHA_Criminalization_Resolution%20Final%20012513.pdf 10

R.S. Jansen, *et al.*, *The Serostatus Approach*, 91 Am. J. Pub. Health 1019 (2001) 20, 27, 32

Roland M.E., *et al.*, *Seroconversion Following Nonoccupational Postexposure Prophylaxis Against HIV*, 41 Clin. Infect. Dis. 1507 (2005) 39

Scott Burris, *et al.*, *Do Criminal Laws Influence HIV Risk Behavior? An Empirical Trial*, 39 Ariz. St. L. J. 467 (2007) 20, 24, 25

Scott Burris, *Law and the Social Risk of Health Care: Lessons from HIV Testing*, 61 Alb. L. Rev. 831 (1998) 27

Scott Burris, *Surveillance, Social Risk, and Symbolism*, 25 J. AIDS (Supp.) 120 (2000) 9, 29, 30

U.S. Dep't of Health & Human Servs., *Newly Diagnosed: What You Need to Know* (2015), *available at* https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/overview/newly-diagnosed/ 7

U.S. Dep't of Justice, *Best Practices Guide to Reform HIV-Specific Criminal Laws to Align with Scientifically-Supported Factors* (2014), *available at* https://www.aids.gov/federal-resources/national-hiv-aids-strategy/doj-hiv-criminal-law-best-practices-guide.pdf 10

U.S. Dep't of Justice, *Title II Highlights*, *available at* http://www.ada.gov/t2hlt95.htm. 36

Univ. of California San Francisco Center for AIDS Prevention Studies, *is there a role for criminal law in HIV prevention?* (2005), *available at* http://caps.ucsf.edu/uploads/pubs/FS/pdf/criminalizationFS.pdf 40

W. Thomas Minahan, *Disclosure Before Exposure: A Review of Ohio's HIV Criminalization Statutes*, 35 Ohio N. U. L. Rev. 83 (2009) 6, 19, 25

The Washington Post/Kaiser Family Foundation, *2012 Survey of Americans on HIV/AIDS* (2012), *available at* https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8334-t.pdf 6

Wendy S. Armstrong & Carlos del Rio, *Gender, Race, and Geography: Do They Matter in Primary Human Immunodeficiency Virus Infection?*, 203 J. Infectious Diseases 437 (2011) 30

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Interest of *Amici Curiae*

Amici Curiae are 9 organizations with a variety of institutional backgrounds, interests, and practices — their particular statements of interest are provided below. What *amici* have in common, and what unites them in filing in this matter, is a belief that HIV-specific criminal laws are discriminatory and violate legal and constitutional rights and human dignity. The animus at the root of HIV-specific criminal laws like the one used to convict Mr. Batista is no different in this regard — it is based in ignorance and outdated misunderstandings about HIV and people living with HIV. A*mici* have an established practice of advocacy for those who suffer discrimination, and each believes that an approach rooted in research, science, and objective facts is the best way to counter prejudice. *Amici* join here to ask this Court to apply reason, objective fact, and established statutory and constitutional precedent to vacate Mr. Batista's conviction and sentence.

The Center for HIV Law and Policy ("CHLP") is a national legal and policy resource and strategy center for people living with HIV and their advocates. CHLP's interest in this case is consistent with its mission to secure fair treatment under the law for all individuals living with HIV and similar disabilities. CHLP believes that inconsistent and unbalanced interpretation and application of criminal and civil laws to people living with HIV reinforces prejudice and undermines government-funded HIV prevention and treatment campaigns.

The American Academy of HIV Medicine ("AAHIVM") is an independent, national organization of HIV specialists and care providers dedicated to promoting excellence in HIV/AIDS care and to ensuring better care for those living with AIDS and HIV disease. AAHIVM's interest in this case is as healthcare providers who seek policies that promote sound health practices and science-based public health policies that affect the care of people living with and at risk for HIV. AAHIVM is opposed to laws that distinguish HIV disease from other

comparable diseases or that create disproportionate penalties for disclosure, exposure, or transmission of HIV disease beyond normal public health ordinances. AAHIVM supports non-punitive prevention approaches to HIV policy centered on current scientific understanding and evidence based research.

GLBTQ Legal Advocates & Defenders ("GLAD") is a public interest legal organization dedicated to ending discrimination based upon sexual orientation, HIV status, and gender identity and expression. For over three decades, GLAD's AIDS Law Project has litigated cases establishing privacy rights, access to health care, equal employment opportunity, and sound public health policies for people with HIV. GLAD was counsel in *Bragdon v. Abbott*, 524 U.S. 624 (1998), which involved a dentist who refused to provide dental care to people with HIV, and established nationwide antidiscrimination protections for people with HIV under the Americans with Disabilities Act.

GLMA: Health Professionals Advancing LGBT Equality ("GLMA") is the largest and oldest association of lesbian, gay, bisexual, and transgender (LGBT) and ally healthcare professionals of all disciplines. GLMA's mission is to ensure equality in healthcare for LGBT individuals and healthcare professionals, using the medical and health expertise of GLMA members in public policy and advocacy, professional education, patient education and referrals, and the promotion of research. GLMA's mission includes addressing the full range of health issues affecting LGBT people, including ensuring that all healthcare providers provide a welcoming environment to LGBT individuals and their families and are competent to address specific health disparities affecting LGBT people, including HIV and AIDS.

Human Rights Campaign ("HRC") – the largest national lesbian, gay, bisexual and transgender political organization – envisions an America where lesbian, gay, bisexual and

transgender people are ensured of their basic equal rights, and can be open, honest and safe at home, at work, and in the community. Among those basic rights is the right to be free from discrimination based on HIV status.

The National Association of Criminal Defense Lawyers ("NACDL") is a nonprofit voluntary professional bar association that works on behalf of criminal defense attorneys to ensure justice and due process for those accused of crime or misconduct. It has a nationwide membership of many thousands of direct members, and up to 40,000 with affiliates. NACDL's members include private criminal defense lawyers, public defenders, military defense counsel, law professors, and judges. NACDL files numerous amicus briefs each year in the U.S. Supreme Court and other federal and state courts, seeking to provide amicus assistance in cases that present issues of broad importance to criminal defendants, criminal defense lawyers, and the criminal justice system as a whole. NACDL has a particular interest in this case as NACDL opposes all laws that base criminal liability and/or penalty enhancements on one's HIV status rather than on the intent to harm another individual. NACDL opposes these laws as they constitute flawed criminal justice policy and flawed public health policy.

The National Center for Lesbian Rights is a national organization committed to protecting and advancing the rights of lesbian, gay, bisexual, and transgender people, including those living with HIV, through impact litigation, public policy advocacy, public education, direct legal services, and collaboration with other social justice organizations and activists.

The Office of the Ohio Public Defender is a state agency designed to represent criminal defendants and to coordinate criminal defense efforts throughout Ohio. The Ohio Public Defender also plays a key role in the promulgation of Ohio statutory law and procedural rules. One of the primary focuses of the Ohio Public Defender is on the appellate phase of criminal

cases, including direct appeals and collateral attacks on convictions. And the primary mission of the Ohio Public Defender is to protect the individual rights guaranteed by the state and federal constitutions through exemplary legal representation. As *amicus curiae*, the Ohio Public Defender offers this Court the perspective of experienced practitioners who routinely handle significant criminal cases in the Ohio appellate courts. The Ohio Public Defender has an interest in the present case insofar as this Court addresses the constitutionality of a felony offense.

Treatment Action Group ("TAG") is an independent AIDS research and policy think tank fighting for better treatment, a vaccine, and a cure for AIDS. TAG's interest in this case is consistent with its mission to ensure that all people with HIV receive lifesaving treatment, care, and information. TAG believes that criminal prosecutions of people with HIV for exposing others to HIV or transmitting the virus undermine 35 years of scientific advances in treatment and care, and challenge efforts by public health officials and medical providers to remove the stigma of having an HIV diagnosis so more people are comfortable getting tested, and receive the appropriate care.

Statement of Facts

Amici adopt the statement of facts as set forth in the Appellant's brief.

Argument

I. Introduction

Appellant Orlando Batista was convicted under Ohio Rev. Code Ann. § 2903.11(B)(1) ("Section 2903.11(B)(1)" or "the Act"), an amendment to the criminal definition of felonious assault enacted in 2000 which expands that definition to include being HIV-positive and engaging in sexual conduct without prior disclosure of one's status. Because the Act reflects the anachronistic, irrational, and discriminatory treatment of persons living with HIV, offending the

federal and Ohio Constitutions, as well as federal statutory law, Mr. Batista's conviction and sentence should be vacated.

When HIV and AIDS first became a national epidemic in the 1980s, it was "growing relentlessly," Larry Gostin, *The Politics of AIDS: Compulsory State Powers, Public Health, and Civil Liberties*, 49 Ohio St. L. J. 1017, 1018 (1989), and while the routes of HIV transmission were scientifically established even then, *see, e.g., Chalk v. U.S. Dist. Ct. Cent. Dist. of California*, 840 F.2d 701, 706 (9th Cir. 1988) (referencing the numerous medical and public health experts who concurred on limited routes of HIV transmission), the larger public was ignorant of this science and an hysteria developed with regard to the threat of contagion. Nat'l Inst. on Drug Abuse, *HIV/AIDS and Drug Abuse: Intertwined Epidemics* (2012), *available at* https:/www.drugabuse.gov/publications/drugfacts/hivaids-drug-abuse-intertwined-epidemics. In the ensuing public health crisis, some policy-makers went so far as to call for quarantine, *see* Gregg Gonsalves, *et al.*, *Panic, Paranoia, and Public Health — The AIDS Epidemic's Lessons for Ebola*, 371 New England J. Med. 2348, 2348 (2014) ("Various politicians called for quarantining of anyone who tested positive for HIV . . . . There was an AIDS-quarantine ballot initiative in California, and various states threatened or passed conditional quarantine measures."), a position that had substantial public support. *See* Harvard Law Review, "Chapter Four: Animus & Sexual Regulation," Developments in the Law: Sexual Orientation and Gender Identity, 127 Harv, L. Rev. 1767, 1788 (2014) ("National polls conducted between 1985 and 1986 found that . . . 28% to 51% supported the full-scale quarantine of AIDS patients.").

The public's fear of people living with HIV was further fueled by rare, sensational accounts of HIV positive individuals alleged to have transmitted the virus wantonly or deliberately. Legislatures reacted. Thus, "[p]artly in response to . . . several [] high profile HIV

transmission cases, the Ohio General Assembly enacted [Section 2903.11(B)(1), among other provisions] and provided severe penalties for those in violation of the statute, demonstrating society's changing view of HIV-infected individuals as potential criminals rather than victims." W. Thomas Minahan, *Disclosure Before Exposure: A Review of Ohio's HIV Criminalization Statutes*, 35 Ohio N. U. L. Rev. 83, 98 (2009); *see also* Mark DeMarino, "A Crime Not to Tell: HIV Laws Debated in Wake of High-Profile Arrest," *Eye on Ohio* (Dec. 26, 2013), *available at* http://eyeonohio.org/a-crime-not-to-tell-hiv-laws-debated-in-wake-of-high-profile-arrest/. As some commentators noted at the time, quick resort to the criminal law reflected that, "[m]any in positions of power will not fear a law they think themselves and their kind immune to, nor will they empathize with those less powerful groups to whom the law will apply predictably. If AIDS primarily afflicted mainstream groups such as white heterosexuals, quarantine and criminalization would not be discussed lightly." Kathleen M. Sullivan & Martha A. Field, *Aids and the Coercive Power of the State*, 23 Harv. C.R.-C.L. L. Rev. 139, 149-50 (1988).

Today, AIDS hysteria has passed and it is possible to view the frenzied, fearful responses of yesteryear for what they were: irrational policies that served only to perpetuate stigma towards disfavored social groups. Thus, the United States Center for Disease Control ("CDC") now publicizes statistical studies showing that many fears related to transmission are unjustified; for example, some sexual activities, like oral sex, carry a risk of HIV transmission from statistically negligible to zero,[1] *see* CDC, *HIV Risk Reduction Tool*, (2016) *available* at http://wwwn.cdc.gov/hivrisk/transmit/activities/, and condom use is highly effective at stopping

[1] That said, public ignorance about HIV transmission remains rampant. According to a study in 2012, approximately 34% of Americans held a misconception that, or did not know if, HIV could be transmitted from a drinking glass, a toilet seat, or by swimming in a pool with a person living with HIV. The Washington Post/Kaiser Family Foundation, *2012 Survey of Americans on HIV/AIDS* at 3 (2012), *available at* https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8334-t.pdf.

HIV transmission, *see* Karen R. Davis and Susan C. Weller, *The Effectiveness of Condoms in Reducing Heterosexual Transmission of HIV*, 31 Family Planning Perspectives 272 (1999) (empirical study in heterosexual couples found condoms between 87-96% effective at reducing risk of HIV transmission); Dawn Smith *et al.*, *Condom Effectiveness for HIV Prevention by Consistency of Use Among Men Who Have Sex with Men in the United States*, 68 J. AIDS 337, 337 (2015) (empirical study finding condom usage 70% effective among men who have sex with men). Accordingly, if laws like § 2903.11(B)(1) were truly designed to limit HIV transmission, they would include incentives to diminish risk, such as by providing a defense for condom use or by recognizing transmission risks. Because the Act does not provide such incentives, and instead merely criminalizes nondisclosure regardless of actual risk, it unsurprisingly has no proven effect on transmission rates. Ohio Rev. Code Ann. § 2903.11(B)(1).

In the years since the HIV public health crisis first emerged and later enactment of § 2903.11(B)(1), the treatment and prevention of HIV has also been transformed; it now can be managed with antiretroviral therapy ("ART") in the form of a single, once-daily pill. For most who take their pill consistently, the HIV virus becomes undetectable, reducing transmission risk and preventing the suffering and death that were the frequent results of HIV in the past. *See* Alison Rodger, *et al.*, *HIV Transmission Risk Through Condomless Sex If the HIV Positive Partner Is on Suppressive ART: PARTNER Study*, Presentation, 21st Conference on Retroviruses and Opportunistic Infections (2014), *presentation slides available at* http://www.chip.dk/portals/0/files/CROI_2014_PARTNER_slides.pdf. People living with HIV can now expect to live a nearly normal lifespan with a high quality of life. U.S. Dep't of Health & Human Servs., *Newly Diagnosed: What You Need to Know* (2015), *available at* https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/overview/newly-diagnosed/.

Thus, 20 year-olds diagnosed with HIV in the United States today have a life expectancy approaching that of their same-aged counterparts without HIV. *See generally* Hasina Samji, *et al.*, *Closing the Gap: Increases in Life Expectancy Among Treated Individuals in the United States and Canada*, 8 PLoS One 1 (2013), *available at* http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0081355. In fact, one recent study found that for individuals living with HIV who adhere to ART treatment and maintain an undetectable viral load, "there was no evidence for a raised risk of death compared with the general population." Alison J. Rodger, *et al.*, *Mortality in Well Controlled HIV in the Continuous Antiretroviral Therapy Arms of the SMART and SPRIT Trials Compared with the General Population*, 27 AIDS 973, 978 (2013). By nonetheless criminalizing – and punishing so harshly – the mere exposure to HIV, without regard to transmission, the Act persists in treating these diseases in a manner that was not justified when the Act was passed, and which is certainly not justified now.

Indeed, with the clarity of intervening years, it is obvious that HIV-specific laws like the Act fail to advance public health because they do nothing to slow the spread of HIV. *See* Kim Buchanan, *When Is HIV a Crime? Sexuality, Gender, and Consent*, 99 Minn. L. Rev. 1231, 1247 (2015) ("[E]mpirical studies have found that criminal laws are unlikely to increase disclosure, reduce risky behaviors, or reduce HIV transmission[.]"). Rather, the evidence discussed in further detail below shows that statutes like the Act likely exacerbate rather than remedy the problem, at least in part because they reinforce the stigma of being HIV positive, making disclosure less rather than more likely. *See* Angelo A. Alonzo & Nancy R. Reynolds, *Stigma, HIV and AIDS: An Exploration and Elaboration of a Stigma Trajectory*, in Medical Sociology, Vol. 3: Coping with Chronic Illness and Disease 216, 224-27 (Graham Scrambler ed. 2005).

That is, the Act remains, despite data suggesting it is actually detrimental to the goal of stopping the spread of HIV.

As time has thus eroded the logic of HIV-specific criminal laws, while also proving them ineffective and counterproductive, it has become apparent that these laws really serve a different purpose, embodying an animus towards those associated with infection. Gostin, *The Politics of AIDS*, 49 Ohio St. L. J. at 1018-19 ("[HIV is] spread predominantly through volitional behavior such as sodomy, prostitution, and the use of intravenous drugs, which are regarded as immoral, even criminal."); *see* Scott Burris, *Surveillance, Social Risk, and Symbolism*, 25 J. AIDS (Supp.) 120, 130 (2000) (discussing HIV-specific criminal laws as, at bottom, condemnation of unpopular social elements). Moreover, the demographics most affected by HIV have shifted and the disease now afflicts primarily historically oppressed populations. New infections among gay black men spiked 22% between 2005 and 2014, and among gay black men under 24 years of age, the increase was 87%. CDC, *HIV Among African American Gay and Bisexual Men* (2016), *available at* http://www.cdc.gov/hiv/group/msm/bmsm/index.html. And emerging data suggest that laws like the Act are disproportionately enforced against historically oppressed populations, including black men, *see* Brad Barber & Bronwen Lichtenstein, *Support for HIV Testing and HIV Criminalization Among Offenders Under Community Supervision*, 33 Research in the Sociology of Health Care 253, 257 (2015), and sex workers, *see* Amira Hasenbush & Brian Zanoni, *HIV Criminalization in California: Penal Implications for People Living With HIV*, Williams Institute at UCLA Law, at 2 (December 2015), *available at* http://williamsinstitute.law.ucla.edu/wp-content/uploads/HIVCriminalization.EvaluationofTransmissionRisk.2016.pdf (in California "the

vast majority (95%) of all HIV-specific criminal incidents impacted people engaged in sex work or individuals suspected engaging in sex work.").

Accordingly, numerous political, medical, and public health organizations have called for repeal of HIV-specific criminal laws — noteworthy opponents include the President's Advisory Council on AIDS ("HIV-specific criminal laws. . . are based on outdated and erroneous beliefs about the routes, risks, and consequences of HIV transmission" and "reinforce the fear and stigma associated with HIV");[2] the United States Department of Justice;[3] the American Medical Association (denouncing HIV-specific criminal laws in light of "stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences");[4] the Infectious Diseases Society of America;[5] the National Alliance of State and Territorial AIDS Directors ("HIV criminalization undercuts our most basic HIV prevention and sexual health messages, and breeds ignorance, fear, and discrimination against people living with HIV.");[6] the

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[2] President's Advisory Council on AIDS, *Resolution on Ending Federal and State HIV-Specific Criminal Laws, Prosecutions, and Civil Commitments* (2013), *available at* http://hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/PACHA_Criminalization_Resolution%20Final%20012513.pdf.

[3] U.S. Dep't of Justice, *Best Practices Guide to Reform HIV-Specific Criminal Laws to Align with Scientifically-Supported Factors* (2014), *available at* https://www.aids.gov/federal-resources/national-hiv-aids-strategy/doj-hiv-criminal-law-best-practices-guide.pdf.

[4] Am. Med. Assoc., *H-20.914 Discrimination and Criminalization Based on HIV Seropositivity* (2014), *available at* http://hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/AMA%20Resolution.pdf

[5] Infectious Diseases Soc. of Am. & HIV Med. Assoc., *Position on the Criminalization of HIV, Sexually Transmitted Infections and Other Communicable Diseases* (2015), *available at* http://www.hivma.org/uploadedFiles/HIVMA/Policy_and_Advocacy/HIVMA-IDSA-Communicable%20Disease%20Criminalization%20Statement%20Final.pdf.

[6] Nat'l Alliance of State and Terr. AIDS Dirs., *National HIV Strategy Imperative: Fighting Stigma and Discrimination by Repealing HIV-Specific Criminal Statutes* (2011), *available at* https://www.nastad.org/sites/default/files/114641_2011311_NASTAD-Statement-on-Criminalization-Final.pdf.

American Academy of HIV Medicine;[7] the National Association of County and City Health Officials;[8] the United States Conference of Mayors ("[R]esearch demonstrates that HIV-specific criminal laws do not reduce transmission or increase disclosure and may discourage HIV testing[.]");[9] the American Psychological Association (criticizing HIV-specific criminal laws because "many HIV disclosure laws were enacted in the 1980s during a climate of fear and uncertainty" and because the penalties they impose "are unjust . . . [and] run counter to public health efforts to reduce HIV transmission");[10] and the Association of Nurses in AIDS Care ("These laws are based on outdated and erroneous information about HIV risk and transmission and further promote misinformation that contributes to stigma and discrimination.").[11]

In the final analysis, the Act is so offensive as to run afoul of the Constitution and laws of the United States and of Ohio. It violates equal protection and cannot survive even the most deferential constitutional analysis, *i.e.*, rational basis review. It also violates prohibitions against discrimination on the basis of a disability under the Americans with Disabilities Act[12] and Section 504 of the Rehabilitation Act.[13] Ultimately, the law under which defendant Batista was

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[7] Am. Acad. of HIV Med., *Policy Position Statement on HIV Criminalization* (2015), *available at* http://www.aahivm.org/Upload_Module/upload/Advocacy/AAHIVM%20-%20PolicyPlatform%20-%20Final%202015.pdf.

[8] Nat'l. Assoc. of Cty. & City Health Officials, *State of Policy: Opposing Stigma and Discrimination against Persons with Communicable Diseases* (2013), *available at* http://www.naccho.org/uploads/downloadable-resources/Policy-and-Advocacy/13-11-Opposing-Stigma-and-Discrimination-against-Persons-with-Communicable-Diseases-2.pdf.

[9] U.S. Conf. of Mayors, *HIV Discrimination and Criminalization* (2013), *available at* http://www.usmayors.org/resolutions/81st_Conference/csj11.asp.

[10] Amer. Psych. Assoc., *Resolution Opposing HIV Criminalization* (2016), *available at* http://www.apa.org/ab
out/policy/hiv-criminalization.aspx.

[11] Assoc. of Nurses in AIDS Care, *Position Statement: HIV Criminalization Laws and Policies Promote Discrimination and Must Be Reformed* (2014), *available at* http://www.nursesinaidscare.org/files/public/ANAC_PS_Criminalization_December12014.pdf.

[12] 42 U.S.C. §§12131,12132; 28 C.F.R. § 35.130 (2016).

[13] 29 U.S.C. § 701 *et seq.* (2014).

sentenced bears no relation to objective facts and serves no purpose but to discriminate against persons with HIV. His conviction and sentence should therefore be vacated.

II. Proposition of Law Number One: The Act Violates the Constitutional Guarantee of Equal Protection.

Section 2903.11(B)(1) violates the federal and State rights to equal protection. U.S. CONST. amend. XIV, § 2; Ohio Const., Art. 1, § 2. It imposes unique burdens on people living with HIV, singling them out for prosecution for what may be harmless behavior without rational justification. Ultimately, the Act is discriminatory, motivated by an animus toward disfavored groups. For these reasons, the Act is unconstitutional and Mr. Batista's conviction and sentence are void.

(1) Equal Protection Forbids Arbitrary, Irrational Classifications.

"The Equal Protection Clause of the Fourteenth Amendment commands that no State shall 'deny to any person within its jurisdiction the equal protection of the laws,' which is essentially a direction that all persons similarly situated should be treated alike." *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 439-440 (1985) (quoting U.S. CONST. amend. XIV, § 2). Likewise, the Ohio Constitution states that "[a]ll political power is inherent in the people. Government is instituted for their equal protection and benefit." Ohio Const., Art. 1, § 2. Ohio Courts treat "the federal and Ohio equal protection provisions [as] 'functionally equivalent,'" employing identical standards of review for both. *Pickaway Cty. Skilled Gaming, L.L.C. v. Cordary*, 127 Ohio St.3d 104, 109 (2010) (internal citation omitted); *accord State v. Klembus*, 146 Ohio St.3d 84, 87 (2016) ("The standards for assessing equal-protection claims are essentially the same under the state and federal Constitutions.").

Under the Equal Protection Clause, claims receive varying levels of scrutiny depending on the particular classification and individual interests burdened. *Heller v. Doe*, 509 U.S. 312,

319-20 (1993); *Cleburne*, 473 U.S. at 439-440; *Pers. Adm'r of Massachusetts v. Feeney*, 442 U.S. 256, 272 (1978); *State v. Thompson*, 95 Ohio St.3d 264, 266-67 (2002). State action that distinguishes between similarly situated persons on the basis of suspect classifications, *see*, *e.g.*, *Grutter v. Bollinger*, 539 U.S. 306, 326 (2003) (race); *Graham v. Richardson*, 403 U.S. 365, 372 (1971) (alienage), or which burdens the exercise of fundamental rights, *see*, *e.g.*, *Shapiro v. Thompson*, 394 U.S. 618, 634 (1969) (right to travel); *Kramer v. Union Free Sch. Dist. No. 15*, 395 U.S. 621, 626 (1969) (right to vote), violates the Constitution "unless necessary to further a compelling governmental interest," *Grutter*, 539 U.S. at 327; *State v. Williams*, 88 Ohio St.3d 513, 530-31 (2000) (noting that heightened scrutiny attaches to suspect classifications of "race, alienage, and ancestry," and to "the right to vote, the right of interstate travel, rights guaranteed by the First Amendment to the United States Constitution, the right to procreate, and other rights of a uniquely personal nature").

State action "neither involving fundamental rights nor proceeding along suspect lines" is subject to rational basis review. *Heller*, 509 U.S. at 320; *accord Nordlinger v. Harn*, 505 U.S. 1, 10 (1993); *Arbino v. Johnson & Johnson*, 116 Ohio St.3d 468, 481 (2007); *McCrone v. Bank One Corp.*, 107 Ohio St.3d 272, 274 (2005). Under this standard, the contested State action must "bear some rational relationship to legitimate state purposes" to pass constitutional muster. *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 40 (1973); *accord Bd. of Trustees of the Univ. of Alabama v. Garrett*, 531 U.S. 356, 366-67 (2001); *Pickaway Cty.*, 127 Ohio St.3d at 110 ("The rational-basis test involves a two-step analysis. We must first identify a valid state interest. Second, we must determine whether the method or means by which the state has chosen to advance that interest is rational."). Rational basis review is thus a more deferential standard than strict scrutiny. Nonetheless, "[t]he State may not rely on a classification whose relationship

to an asserted goal is so attenuated as to render the distinction arbitrary or irrational." *Cleburne*, 473 U.S. at 445 (striking down denial of zoning variance to create group home for the intellectually impaired under rational basis review); *see also Romer v. Evans*, 517 U.S. 620 (1996) (striking down Colorado constitutional amendment denying civil rights protection to homosexuals under rational basis review); *Dep't. of Agric. v. Moreno*, 413 U.S. 528, 534 (1973) (striking down amendment to Federal Food Stamp Act that denied provision to unrelated persons cohabiting under rational basis review); *State v. Noling*, Slip Opinion No. 2016-Ohio-8252, at 10 (Dec. 21, 2016) (striking provision of Ohio code that gives capital defendants only discretionary review by Ohio Supreme Court of post-conviction denial of DNA testing because "providing only a discretionary appeal is not rationally related to the governmental purpose of expeditiously enforcing final judgments"); *State v. Mole*, No. 2013-1619, 2016 WL 4009975, at *12-14 (Ohio July 28, 2016) (striking down sexual battery law which applied lesser *mens rea* requirement uniquely to law enforcement officers).

Because prejudice towards a politically disfavored group is invariably arbitrary, State action motivated by this purpose fails even rational basis review. *Noling*, Slip Opinion No. 2016-Ohio-8252, at 5 ("'The Constitution's guarantee of equality 'must at the very least mean that a bare congressional desire to harm a politically unpopular group cannot' justify disparate treatment of that group.'") (internal citations omitted); *Cleburne*, 473 U.S. at 448 (action motivated by "mere negative attitudes, or fear, unsubstantiated by factors that are properly cognizable" is forbidden); *Moreno*, 413 U.S. at 534 ("[I]f the constitutional conception of 'equal protection of the laws' means anything, it must at the very least mean that a bare congressional desire to harm a politically unpopular group cannot constitute a *legitimate* governmental interest.") (emphasis in original) (internal citation omitted). Under rational basis review, a State

classification may be shown to be prejudicial because the burdens imposed on the classified group are so unrelated to the purpose of the law as to betray a true purpose of irrational fear or unlawful prejudice. *Romer*, 517 U.S. at 632 (contested State action's "sheer breadth is so discontinuous with the reasons offered for it that the amendment seems inexplicable by anything but animus towards the class it affects; it lacks a rational relationship to legitimate state interests."); *Cleburne*, 473 U.S. at 450 (inferring motivation of "irrational prejudice" where proffered justifications did not withstand analysis); *Moreno*, 413 U.S. at 537 ("[I]n practical effect, the challenged classification simply does not operate so as rationally to further [the asserted State interest.]"). Additionally, a classification may manifest prejudice if it 'singles out' a particular group among others that are similarly situated, without justification. *Romer*, 517 U.S. at 633. In sum, even under the more lenient standard described by rational basis review, equal protection requires that State action be founded in objectively reasonable facts which support the burdens imposed on the classified group, as well as any singling out of the classified group relative to other groups that are similarly situated. *Vance v. Bradley*, 440 U.S. 93, 111 (1979) (A claimant will prevail by showing that the "legislative facts on which the classification is based could not reasonably be considered to be true by the governmental decisionmaker."); *accord Romer*, 517 U.S. at 635; *Mole*, No. 2012-1619, 2016 WL 4009975, at *6 (to survive rational basis review, it must be the case that "the legislative facts on which the classification is apparently based rationally may have been considered to be true by the governmental decisionmaker").

(2) <u>The Act Singles Out People Living with HIV for Differential Treatment.</u>

Section 2903.11(B) makes it a second degree felony assault for persons living with HIV – *and only such persons* – to have sexual conduct with another person without first disclosing their HIV status:

> No person, with knowledge that the person has tested positive as a carrier of a virus that causes acquired immunodeficiency syndrome, shall knowingly . . . [e]ngage in sexual conduct with another person without disclosing that knowledge to the other person prior to engaging in the sexual conduct.

Ohio Rev. Code Ann. § 2903.11(B)(1). The term "sexual conduct" is defined as: "vaginal intercourse between a male and a female; anal intercourse, fellatio, and cunnilingus between persons regardless of sex; . . . the insertion, however slight, of any part of the body . . . into the vaginal or anal opening of another," Ohio Rev. Code Ann. § 2907.01(A), and "insertion of an instrument, apparatus, or other object that is not a part of the body into the vaginal or anal opening of another . . . [if] the offender knew at the time of the insertion that the instrument, apparatus, or other object carried the offender's bodily fluid." Ohio Rev. Code Ann. § 2903.11(E)(4).[14] As a second degree felony, a violation of R.C. § 2903.11(B)(1) carries a prison term of between two (2) and eight (8) years. Ohio Rev. Code. Ann. § 2929.14.

The manner in which § 2903.11(B)(1) singles out people living with HIV is thus patent: no other class of persons must disclose private medical information prior to sexual conduct or risk felony prosecution. More pointedly, among people living with sexually transmitted or contagious diseases, only those living with HIV must disclose their status under threat of criminal law.

By contrast, the risk of spread of other communicable diseases is regulated in a manner that imposes significantly lighter burdens on the individuals afflicted. Thus, the criminal offense of "spreading contagion" holds:

> No person, knowing or having reasonable cause to believe that he is suffering from a dangerous, contagious disease, shall knowingly fail to

[14] Section 2903.11(E)(4) expressly adopts the definition of "sexual conduct" from R.C. § 2907.01(A) with the limited exception that § 2903.11(E)(4) defines sexual conduct to include insertion of an instrument or object only where it is known to carry the accused's bodily fluid, as noted above.

> take reasonable measures to prevent exposing himself to other persons, except when seeking medical aid.

Ohio Rev. Code Ann. § 3701.81. This statute does not distinguish between types of dangerous, contagious diseases, and its violation is a second degree misdemeanor, *Mussivand v. David*, 45 Ohio St.3d 314, 319 (1989), punishable by a maximum of 90 days imprisonment and a fine of $750. Ohio Rev. Code Ann. § 2929.21. In other words, one who knowingly fails to take reasonable measures to prevent the spread of a dangerous, contagious illness is already punishable under Ohio criminal law and may receive punishment of, at most 90 days in prison; while a person living with HIV or AIDS is subject to imprisonment for from 2 to 8 *years* for sexual conduct without prior disclosure.

(3) The Act Cannot Survive Rational Basis Review.

The court below held that Mr. Batista's equal protection claim "does not involve a 'fundamental right' or 'suspect classification' warranting strict scrutiny," and therefore must be analyzed under rational basis review. *State v. Batista*, 1st Dist. Hamilton No. C-150341, 2016 WL 2610027, at *1 (1st Dist. May 6, 2016). Assuming *arguendo* that rational basis review is the appropriate standard,[15] the Act cannot satisfy even this deferential requirement, contrary to the appellate court's decision. Though that court was no doubt correct that "[s]topping the spread of

[15] Undersigned *amici* do not, in fact, concede that the Act neither implicates fundamental rights, nor employs a suspect classification. Though it is not necessary to the decision here, because the Act cannot survive even rational basis review, the Act encroaches on fundamental rights against compelled speech, *Knox v. Serv. Emps. Union, Local 100*, 132 S.Ct. 2277, 2288 (2012) ("The government may not prohibit the dissemination of ideas that it disfavors, nor compel the endorsement of ideas that it approves," a prohibition that is violated by the Act's disclosure requirement), and privacy, *Whalen v. Roe*, 429 U.S. 589, 598 (1977) (individuals have a right to privacy in confidential medical information, which the Act violates both by mandating disclosure and by making medical information public through the criminal process). People living with HIV may also fit the doctrinal definition of a suspect class as "one 'saddled with such disabilities, or subjected to such a history of purposeful unequal treatment, or relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process.'" *Williams*, 88 Ohio St.3d at 530 (quoting *Massachusetts Bd. of Retirement v. Murgia*, 427 U.S. 307, 313 (1976)).

HIV is a legitimate state interest, as it furthers the safety and welfare of Ohio's citizens," *id.* at 4, it erred by simply assuming, without any basis or argument, that "[r]equiring an HIV-positive individual to disclose his or her status before engaging in sexual conduct is rationally related to stopping the spread of HIV." *Id.* at 4.

To the contrary, the Act is an unreasonable and arbitrary means of preventing HIV transmission for at least three reasons: first, because it is so overinclusive as to be arbitrary, in that it criminalizes behavior that carries no risk of infection; second, because legislation of this kind is empirically proven to have no effect on the rate of HIV infection in the population at large; and third, because it is counterproductive, in that it promotes stigma for people living with HIV, which in turn effects their willingness both to get tested and, if they are aware of their HIV-positive status, to disclose that status to prospective sexual partners. At the end of the day, the absence of any reasonable relationship between the Act and the goal of preventing new HIV infections compels, as a matter of law, the inference that the Act reflects animus – a conclusion that is bolstered by the way that HIV is singled out in Ohio law relative to other contagious diseases. Animus, of course, is an unconstitutional State purpose under any circumstances, and accordingly, the Act is unconstitutional on its face. Each of these points is discussed in turn, below.

(A) ***The Act's Classification Is Arbitrary Because It Is OverInclusive.***

The Act's requirement of disclosure of HIV status prior to sexual conduct "is so attenuated" from the goal of stopping the spread of HIV "as render the distinction arbitrary and irrational." *Cleburne*, 473 U.S. at 446. This is because it is overinclusive, criminalizing a wide-spectrum of behavior that poses no risk of HIV transmission and no threat to the public welfare. First, the Act is overinclusive because it disregards significant differences in the risks of transmission through sexual activity. *See*, *e.g.*, J. Lerhman, *et al.*, *Prevalence and Public Health*

Implications of State Laws that Criminalize Potential HIV Exposure in the United States, 18 AIDS and Behav 997, 1003 (2014) ("The risk of acquiring HIV varies widely by route of exposure."). In particular, notwithstanding that condoms are proven to lower the risk of transmission considerably, condom use is no defense under the Act. W. Thomas Minahan, *Disclosure Before Exposure: A Review of Ohio's HIV Criminalization Statutes*, 35 Ohio N. U. L. Rev. 83, 102 (2009) ("While public health officials agree that condom use significantly reduces the chance for infection, the Ohio statutes have no provision for this or other safe sex precautions that could mitigate the offense."); CDC, *Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV* (2016), *available at* http://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html (self-reported regular condom use proven to reduce risk of transmission markedly). The Act thus refuses to distinguish between those who take affirmative measures to prevent transmission and those who do not, a patently irrational policy that disincentivizes conduct that ought to be encouraged. Minahan, *Disclosure Before Exposure*, 35 Ohio N. U. L. Rev. at 106 ("[A]llowing no provision for mitigation or an affirmative defense for condom use simply makes no sense.").

The statute also does not distinguish among defendants based on factors that measurably affect individual infectiousness and the ability to transmit HIV.[16] This, too, is irrational. For

[16] Indeed, the Act ignores all of the many factors going to the risk of transmission, including many more than *amici* highlight, above. For example, additional relevant factors include circumcision, the presence or absence of other sexually transmitted diseases, stage of infection of the person who is HIV-positive, immune system strength of uninfected partner, preventative treatment via ART by the uninfected partner (known as "PReP", which when taken consistently reduces transmission of high risk individuals by up to 92%), and whether the infected partner is someone whose HIV viral load remains relatively low and stable even in the absence of treatment over a period of years (such individuals are medically termed "nonprogressors"). Felorencia Pereya, *et. al., Genetic And Immunologic Heterogeneity Among Persons Who Control HIV Infection In The Absence Of Therapy*, 197 J. Infect. Dis. 563 (2008); CDC, *HIV Risk and Prevention* (2016), *available at* http://www.cdc.gov/hiv/risk/index.html; *see* Burris, *Do Criminal*

example, appropriate treatment through antiretroviral therapy "reduces both plasma and genital fluid viral load," meaning there is less virus present in the bodily fluids of a potential defendant and correspondingly, less possibility of infection through exposure. R.S. Jansen, *et al.*, *The Serostatus Approach*, 91 Am. J. Pub. Health 1019, 1020 (2001); Galletly & Pinkerton, *Toward Rational Criminal HIV Exposure Laws*, 32 J. L. Med. & Ethics at 328 (calling viral load the most significant factor in probability of HIV transmission). Regular treatment through ART can decrease viral load to undetectable levels, reducing an already-low risk of infection by 96%. Cohen M. *et al.*, *Prevention of HIV-1 Infection with Early Antiretroviral Therapy*, 365 New England J. Med. 493 (2011). But the Act does not take these facts into account.[17]

Likewise, there is significant variance in the risk of transmission between types of sexual activity. Unprotected, receptive anal sex is estimated to transmit infection at the rate of 138 times per 10,000 instances (1.38%), insertive vaginal intercourse is estimated to transmit in only 4 instances out of 10,000 (0.04%), and oral sex, both fellatio and cunnilingus, carry a rate of transmission deemed negligible at beneath 1/10,000 (less than 0.01%). CDC, *Estimated Per-Act Probability of Acquiring HIV from an Infected Source, by Exposure Act* (2016), *available at* http://www.cdc.gov/hiv/risk/estimates/riskbehaviors.html. Nonetheless, the Act makes no distinction between types of sexual activity, even in the face of these established facts.

In other words, the risk of infection through sexual activity varies from 1.4% per encounter for unprotected anal sex (insertive partner HIV positive person and not in treatment) *at*

Laws Influence HIV Risk Behavior?, 39 Ariz. St. L. J. at 477; Galletly & Pinkerton, *Toward Rational HIV Exposure Laws*, 32 J. L. Med. & Ethics at 328. None of these are considered.

[17] In one recent study that followed 767 couples where one partner was living with HIV and on therapy with an undetectable viral load, there were no transmissions despite condomless sex and an estimated 44,400 anal or vaginal sexual acts. Alison J. Rodger, *et al.*, *Sexual Activity without Condoms and Risk of HIV Transmission in Serodifferent Couples When the HIV-Positive Partner Is Using Suppressive Antiretroviral Therapy,* 316 J. Am. Med. Assn. 171, 172 (2016).

the high end to a probability that is statistically insignificant for a variety of conduct, including oral sex, sex with a condom, or any sexual activity where the HIV positive individual has an undetectable viral load. *See* Galletly & Pinkerton, *Toward Rational Criminal HIV Exposure Laws*, 32 J. L. Med. & Ethics at 328 ("[T]he likelihood of infection — *even if exposure does occur* — is very small for most [sexual acts] and negligible for the remainder.") (emphasis in original). The Act is therefore overinclusive to the point of irrationality because it prohibits a significant amount of conduct that carries no actual risk of infection and therefore threatens no harm whatsoever to the public. *Id.* at 335 ("The lack of consideration given to risk-reduction measures . . . is a striking omission"); Buchanan, *When Is HIV a Crime?*, 99 Minn. L. Rev. at 1239-40 (criticizing convictions in cases where sexual activity bore "no realistic possibility of transmission."). Overinclusiveness of precisely this kind is just the sort of irrationality that the Supreme Court has cited in striking down State laws under rational basis review. *See Romer*, 517 U.S. at 635 (striking down Colorado Amendment 2 in part because "[t]he breadth of the amendment is so far removed from [the State's] justifications that we find it impossible to credit them"); *Zobel*, 457 U.S. at 61 (Alaska law which apportioned revenue surplus to citizens commensurate with length of State residency could not be sustained by purported State interests that did not justify breadth of windfall provided to residents of long standing).

These background facts about the many variables that affect the risk of HIV transmission through sexual conduct, including several that are within the control of an HIV positive person and may be intentionally adopted to mitigate risk, mean that the Act's disregard of such facts results in a criminal statute with a lower *mens rea* requirement than is applicable to any general criminal law provision in the State of Ohio. For instance, criminal negligence, the least culpable mental state, is found:

[W]hen, because of a substantial lapse from due care, the person fails to perceive or avoid a risk that the person's conduct may cause a certain result or may be of a certain nature. A person is negligent with respect to circumstances when, because of a substantial lapse from due care, the person fails to perceive or avoid a risk that such circumstances may exist.

Ohio Rev. Code Ann. § 2901.22(D). But as just discussed, a person with knowledge that he is HIV-positive could exercise due care and mitigate all risk prior to sexual conduct – for example, by maintaining regular treatment resulting in a viral load that is undetectable, by wearing a condom, and/or by engaging in "sexual conduct" with a low likelihood of transmission – and yet nonetheless face prosecution for failure to disclose. The Act thus amounts to a strict liability statute reserved for people living with HIV. But strict liability in the criminal law is only permitted where *mens rea* can be "imputed from any factor that might justify inferring a guilty knowledge or a nefarious intent." *Mole*, No. 2013-1619, 2016 WL 4009975, at *17 (striking down under equal protection a criminal law classification that assigned strict liability for certain sexual offenses to law enforcement officers uniquely, since the classification of law enforcement officer did not support inference of guilty knowledge or intent); *see also U.S. v. U.S. Gypsum Co.*, 438 U.S. 422, 437-38 (1978) ("While strict-liability offenses are not unknown to the criminal law and do not invariably offend constitutional requirements, the limited circumstances in which Congress has created and this Court has recognized such offenses attest to their generally disfavored status.") (internal citations omitted). Of course, guilty knowledge or intent cannot be inferred from the mere fact of one's HIV positive status – that Ohio nonetheless endorses such an inference in irrational, and ultimately promotes stigma and reflects animus, as detailed below.

(B) *HIV-Specific Criminal Laws Are Empirically Proven to Have No Effect on the Spread of HIV.*

Furthermore, research has demonstrated that criminal laws like the Act simply do not work. *See* Buchanan, *When Is HIV a Crime?*, 99 Minn. L. Rev. at 1247 (discussing empirical studies showing failure of HIV-specific criminal laws to reduce rate of HIV transmission); President's Advisory Council on AIDS, *Resolution on Ending Federal and State HIV-Specific Criminal Laws* ("[A]n evidence-based approach to disease control and research demonstrates that HIV-specific laws do not reduce transmission or increase disclosure[.]"). In study after study, medical and public health experts unfailingly conclude that HIV-specific criminal laws do not actually promote disclosure of status prior to sex. *See* Carol L. Galletly, *et al.*, *New Jersey's HIV Exposure Law and the HIV-Related Attitudes, Beliefs, and Sexual Seropositive Status Disclosure Behaviors of Persons Living with HIV*, 102 Am. J. Pub. Health 2135, 2139 (2012) (concluding "awareness that New Jersey has an HIV exposure law had little if any effect on the disclosure behavior of [people living with HIV and AIDS]."); Carol Galletly, *et al.*, *A Quantitative Study of Michigan's Criminal HIV Exposure Law*, 24 AIDS Care 174, 178 (2012) (same, in Michigan); Patrick O'Byrne, *et al.*, *Nondisclosure Prosecutions and HIV Prevention: Results from an Ottawa-Based Gay Men's Sex Survey*, 24 J. Nurses Assn. AIDS Care 81, 85 (2013) (in survey of 441 men who have sex with men, finding that between 10-20% reported that awareness of prosecutions for nondisclosure led to *higher* risk behavior).

Indeed, the Act in Ohio has had no discernable effect in reducing HIV transmissions. Ohio is one of the leading states in the country for the number of HIV diagnoses, ranking 12 out of 50 in 2013. CDC, *Ohio – 2015 State Health Profile* (2016), *available at* https://www.cdc.gov/nchhstp/stateprofiles/pdf/ohio_profile.pdf. Enacted in its present form in 2000, the Act has not been bolstered by any evidence that it is causing a reduction of these rates;

in Ohio, new HIV infections per year have increased from approximately 620 in 2000 to 925 in 2010. Ohio Dep't. of Health, *History of Ohio's HIV/AIDS Epidemic, 1981-2010* (2016), *available at* https://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/health%20statistics%20-%20disease%20-%20hiv-aids/12OhioChart.pdf. This trend has continued, with approximately 1000 new HIV infections in Ohio each year from 2010 to 2014. Ohio Dep't. of Health, *Diagnosis of HIV and/or AIDS Reported in Ohio*, *available at* https://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/health%20statistics%20-%20disease%20-%20hiv-aids/WebTables12.pdf.

Nor do laws like the Act foster behavior that mitigates the risk of transmission. *See* Scott Burris, *et al.*, *Do Criminal Laws Influence HIV Risk Behavior? An Empirical Trial*, 39 Ariz. St. L. J. 467 (2007) (comparing self-reported behavior of people living with HIV and AIDS and those at risk of infection in Illinois and New York, States with and without HIV-specific criminal laws, respectively, and finding no difference in condom use); Galletly, *Michigan's HIV Exposure Law*, 24 AIDS Care at 178 (Michigan study showed no correlation between awareness of HIV-specific criminal law and either abstinence, number of sexual partners, or condom use). Of course, this is unsurprising, given that the Act does not create an affirmative defense or mitigate the penalty for individuals who use condoms, receive regular treatment and maintain a low viral load, or engage in forms of sexual conduct with a lower probability of transmission. As a result, despite nation-wide proliferation of laws like the Act, "new HIV cases have remained steady" and, in fact, among young black men who have sex with men, rates "have risen sharply in recent years." Bisarber & Lichtenstein, *Support for HIV Testing* at 255 (noting new infection rate constant from 2010-2015 at approximately 50,000 cases per year). By any reasonable metric, "[t]he criminalization of HIV has been a strange, pointless exercise in the long fight to control

HIV. It has done no good." Burris, *Do Criminal Laws Influence HIV Risk Behavior?*, 39 Ariz. St. L. J. at 467.

(C) ***Criminalization of Nondisclosure Is Counterproductive.***

Not only are HIV-specific criminal laws like the Act proven to have no effect on the spread of HIV, but they are, in fact, counterproductive. Minahan, *Disclosure Before Exposure*, 36 Ohio N. U. L. Rev. at 106 ("Ohio's [HIV-specific criminal exposure] statute[] as now written contravene[s] long established public health measures."). For many years now, the medical and public health communities have been in agreement as to how best to stop the spread of HIV: "diagnosing all HIV-infected persons, linking them to appropriate high-quality care and prevention services, helping them adhere to treatment regimens, and supporting them in adopting and sustaining HIV risk reduction behavior." CDC, *Prevention Strategies for Individuals with HIV*, The Serostatus Approach (2001), *available at* http://www.cdc.gov/hiv/research/seroststatusapproach/strategies.html. The Act undermines these objectives because it promotes stigma, which in turn discourages both HIV testing and subsequent treatment.

The Act discourages testing because of the way it reinforces stigma. Stigma may be defined as "a powerful discrediting and tainting social label that radically changes the way individuals view themselves and are viewed as persons." Alonzo & Reynolds, *Stigma, HIV and AIDS* at 217. HIV and the people it affects are stigmatized to an "extraordinary" degree because the disease is:

1. associated with deviant behavior, both as a product and as a producer of deviant behavior;
2. viewed as the responsibility of the individual;
3. tainted by an historical belief as to its immorality and/or thought to be contracted via a morally sanctionable behavior . . . ;

4. perceived as contagious and threatening to the community;

5. associated with an undesirable and an unaesthetic form of death; and

6. not well understood by the law community and viewed negatively by health care providers.

Id. at 219-20. That is, public attitudes about HIV embody the Supreme Court's warning that, "society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment." *Sch. Bd. v. Arline*, 480 U.S. 273, 284 (1987); *see* Harvard Law Review, "Chapter Four: Animus & Sexual Regulation," 127 Harv. L. Rev. at 1786-87 ("[I]t is almost unremarkable to observe that HIV/AIDS is a tremendously stigmatized disease affecting already-stigmatized subpopulations. HIV stigma has been '[f]ueled in part by the disfavored social standing of many of the persons who were first infected, in part by communal desires to blame the afflicted and thus deny personal vulnerability, and in part by long-standing social aversion to sexually transmitted diseases.'") (internal citation omitted).

Laws like Section 2903.11(B)(1), of course, not only reflect but actively bolster stigma. By singling out HIV for unique criminal regulation without regard to actual risk of transmission, the Act inaccurately signals that HIV is uniquely fearsome and dangerous to society. *See* Buchanan, *When Is HIV a Crime?*, 99 Minn. L. Rev. at 1273 (concluding that regulation that criminalizes nondisclosure of HIV, without regard to risk of transmission, uniquely stigmatizes HIV). The Act also promotes stigma because its minimal *mens rea* requirement disregards the "substantial and qualitative difference between failing to disclose one's HIV positive serostatus to a prospective partner and intentionally trying to infect that partner;" in this manner, the Act paints people living with HIV who decline to disclose their status as maliciously trying to infect the public, "a gross mischaracterization of the motives of the vast majority of sexually-active HIV-infected persons[.]" Galletly & Pinkerton, *Toward Rational Criminal HIV Exposure Laws*,

32 J. L. Med. & Ethics at 335. Finally, the Act reinforces stigma because it penalizes exposure without regard to a person's viral load and without regard to actual HIV transmission ultimately takes place, further inflating the false belief that HIV is uniquely deadly.

As reinforced by the Act, stigma associated with HIV provides a powerful disincentive for individuals with HIV to learn their status. By treating knowledge of one's HIV status while engaging in otherwise legal conduct as a felony, the Act equates that knowledge with "potential for rejection by family, partners, friends and co-workers . . . . [as well as with] many forms of discrimination." Alonzo & Reynolds, *Stigma, HIV and AIDS*, at 223; *accord* Scott Burris, *Law and the Social Risk of Health Care: Lessons from HIV Testing*, 61 Alb. L. Rev. 831, 889 (1998) ("Given the complexity of the decision to be tested, it seems likely that for many people fears of social risk may tip the balance[.]"). Such stigma likewise discourages the kind of open communication with sexual partners that permits shared understanding of the risks of sexually transmitted diseases and available means for intimacy without risk of infection. Barber & Lichtenstein, *Support for HIV Testing* at 254 ("[People living with HIV] have little incentive to be frank with sexual partners if they face increased HIV stigma[.]"). The social science also suggests that stigma encourages nondisclosure as a form of denial, leading to "activities that dismiss and deny the diagnosis, such as unprotected sex with unknowing partners[.]" Alonzo & Reynolds, *Stigma, HIV and AIDS*, at 227. In this manner, the Act significantly undermines the public health goal of preventing the spread of HIV, and for this reason, too, is irrational.

Testing is obviously central to any rational public health response to HIV; not only does testing facilitate treatment of people with HIV and secure better health outcomes for those already infected, it also reduces the risk of further transmission. Jansen, *The Serostatus*

Approach, 91 Am. J. Pub. Health at 1020.[18] That is because testing prompts people living with HIV to enter into treatment, resulting, as previously noted, in a reduction of their viral load and thus making further transmission less probable. *Id.* at 1020-21. But testing also thwarts the spread of HIV because, as research demonstrates, people generally adopt lower risk behavior upon learning they are HIV positive. *Id.*; Buchanan, *When Is HIV a Crime?*, 99 Minn. L. Rev. at 1245 ("People who know they have HIV are more likely to disclose, take precautions, and receive treatment than those who have not been tested, and are much less likely than their untested counterparts to transmit HIV."); Assn. of Nurses in AIDS Care, *HIV Criminalization Laws and Policies Promote Discrimination and Must Be Reformed* (2014) ("[S]tudies have shown that HIV+ individuals who know their status are significantly less likely to engage in sexual behaviors that may increase risk of transmission to a partner than HIV+ individuals who remain unaware they are infected.").

And empirical evidence supports the argument that laws like the Act disincentivize testing by promoting stigma, with significant counterproductive effects. For example, one study found that "[f]or every unit of increase in the media reporting of HIV criminalization, a 7% to 9% decrease of the HIV testing rate" could be expected. Sun Goo Lee, *Criminal Law and HIV Testing: Empirical Analysis of How At-Risk Individuals Respond to the Law*, 14 Yale J. Health Pol'y, L. & Ethics 194, 233 (2014). By this rationale, Mr. Batista's case, and the publicity generated by it, is not so much deterring nondisclosure of HIV-positive status prior to sex as it is

[18] Providing a disincentive to testing is a particularly harmful consequence of the Act, because, as it is, "only 45% of adults hav[e] ever been tested for HIV in their lifetimes and only about 10% hav[e] been tested within the last twelve months." Harvard Law Review, "Chapter Four: Animus & Sexual Regulation," 127 Harv. L. Rev. 1767, 1781 (2014). This is particularly troubling because individuals who are not aware of their HIV positive status account for "over half of all new HIV infections in the United States." *Id.*

deterring testing by people at risk of having or contracting HIV. This is tragic and, as a matter of law, irrational.

(D) *The Absence of Any Rational Basis for the Act Suggests Unlawful Animus.*

Where State action imposes special burdens on a unique class with no rational basis, "an inevitable inference [arises] that the disadvantage imposed is born of animosity towards the class of persons affected." *Romer*, 517 U.S. at 634; Harvard Law Review, "Chapter Four: Animus & Sexual Regulation," 127 Harv, L. Rev. at 1774 ("The biggest red flag [signaling legislative animus] appears to be the singling out of specific groups for special burdens or disabilities that the political majority enjoys immunity from."). Such an inference is certainly warranted here. HIV first emerged in the United States among "gay men and intravenous drug users," groups historically subjected to "a persistently negative societal response[.]" Alonzo & Reynolds, *Stigma, HIV and AIDS*, at 216; *accord* Burris, *Surveillance, Social Risk, and Symbolism*, 25 J. AIDS at 125 ("The stigma and hostility [associated with HIV] are magnified by the fact that HIV is spread by behavior that is itself socially problematic: both drug use and homosexuality are independently subject to stigma and social hostility."); Buchanan, *When Is HIV a Crime?*, 99 Minn. L. Rev. at 1294-95 ("Since the beginning of the epidemic, HIV has been associated with stigmatized groups of people. . . . HIV was often described in popular discourse as a 'gay plague.'"). Where "the vulnerable social position of the burdened group is obvious," as here, equal protection law does not require express evidence of a legislative desire to harm – instead, courts properly consider "social and historical context" to "probe[] for impermissible motives." Harvard Law Review, "Chapter Four: Animus & Sexual Regulation," 127 Harv, L. Rev. at 1774-75. As a result, resort to the criminal law in response to the HIV crisis is appropriately viewed as a moral judgment about those deemed at fault for its emergence:

> [Criminal laws] represent an assertion of social control over those at risk of HIV, and their passage in a legislative or administrative struggle often represents a victory for social factions who not only believe that homosexuality and drug use are wrong, but also that the toleration of these behaviors undermines their own values and social status.

Burris, *Surveillance, Social Risk, and Symbolism*, 25 J. AIDS at 130.

Moreover, the passage of time has only exacerbated the discriminatory nature of the Act. As treatment through ART has rendered the negative reaction to people living with HIV less justifiable, that reaction nonetheless persists, all while HIV has become a disease that increasingly and disproportionately affects black communities within the United States. Brook Kelly, *The Modern HIV/AIDS Epidemic*, 41 U. Balt. L. Rev. 355, 355-56 (2012). Indeed, the CDC reports that "[b]lacks/African Americans have the most severe burden of HIV and all racial/ethnic groups in the United States. Compared with other races and ethnicities, African Americans account for a higher proportion of new HIV diagnoses, those living with HIV, and those ever diagnosed with AIDS." CDC, *HIV Among African Americans* (2016), *available at* http://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html. HIV also disproportionately affects the poor: a CDC study found that "HIV prevalence rates in urban poverty areas were inversely related to socioeconomic status;" indeed, more than one out of 50 poor urban residents is HIV positive. CDC, *Communities in Crisis: Is There a Generalized HIV Epidemic in Impoverished Urban Areas of the United States?* (2016), *available at* http://www.cdc.gov/hiv/group/poverty.html. Further, HIV is disproportionately linked to morbidity for poor, black, southern women. Aamie L. Meditz, *et al.*, *Sex, Race, and Geographic Region Influence Clinical Outcomes Following Primary HIV-1 Infection*, 203 J. Infectious Diseases 442, 449-50 (2011) ("socioeconomic circumstances of nonwhite women in the South are a major determinant of elevated morbidity in this group"); Wendy S. Armstrong & Carlos del Rio, *Gender, Race, and Geography: Do They Matter in Primary Human Immunodeficiency Virus*

Infection?, 203 J. Infectious Diseases 437, 437 (2011) ("Women, nonwhites, and those living in the Southern United States were significantly less likely to start antiretroviral therapy and were more likely to have AIDS related complications."). In other words, HIV today disproportionately burdens persons who have borne the greatest historical discrimination, and who are consequently among society's most marginalized members. *See* Kelly, *The Modern HIV/AIDS Epidemic*, 41 U. Balt. L. Rev. at 355 ("The HIV epidemic is driven by the same social and structural factors that perpetuate current inequalities found in the United States[.]"). The Act, of course, perpetuates this discrimination, especially given available data suggesting that, nationwide, HIV-specific criminal laws are disproportionately enforced against black men. *See* Barber & Lichtenstein, *Support for HIV Testing* at 257; Buchanan, *When Is HIV a Crime? Sexuality, Gender, and Consent*, 99 Minn. L. Rev. at 1294-1304 (discussing prosecution of HIV-specific criminal laws as disproportionately targeted at black men for nondisclosure in cases of sexual activity with white women).

The Act singles out historically oppressed individuals in a manner suggestive of unconstitutional animus. *See Romer*, 517 U.S. at 633 (calling Colorado Amendment 2 "at once too narrow and too broad" because [i]t identifies persons by a single trait and then denies them protection across the board"); *Cleburne*, 473 U.S. at 449-50 (striking down State action where justifications applied equally to groups not similarly burdened). That is, as previously noted, Section 2903.11(B), and the corresponding burden it imposes, is unique in Ohio law. Ohio does not explicitly require, under penalty of felony prosecution, prior disclosure and consent prior to sexual conduct with regard to any other communicable disease. For example, individuals knowingly infected with human papillomavirus (HPV), herpes, tuberculosis, and hepatitis cannot be prosecuted for the nondisclosure of their status prior to sexual activity. *See* Buchanan, *When*

Is HIV a Crime?, 99 Minn. L. Rev. at 1279 ("Other potentially deadly communicable diseases, such as hepatitis, human papillomavirus (HPV), or tuberculosis, are not subject to the fear and stigma associated with HIV, and are not in practice treated as crimes.").

This singling out of HIV and of those living with that disease is medically unfounded. HIV is now treatable through ART via a once-daily pill that both prevents the onset of AIDS and allows infected persons to live virtually symptom-free. *See* Jansen, *et al.*, *The Serostatus Approach*, 91 Am. J. Pub. Health at 1020. With appropriate treatment, people living with HIV can now live a normal life-span with a quality of life that is minimally encumbered by illness. *See* Buchanan, *When Is HIV a Crime? Sexuality, Gender, and Consent*, 99 Minn. L. Rev. at 1244 ("[ART] has transformed HIV from a lethal disease to a chronic, though life-changing, illness that is manageable with medication."). And while it is true that, untreated, HIV frequently leads to AIDS, which in turn can be fatal, this fact does not distinguish HIV. Tuberculosis, for example, may be fatal if untreated, CDC, *Basic TB Facts* (2016), *available at* http://www.cdc.gov/tb/topic/basics/default.html, and HPV, which is untreatable and accounts for 71% of all new sexually transmitted infections each year, can cause cervical and other fatal cancers, CDC, *Genital HPV Infection - Fact Sheet* (2016), *available at* http://www.cdc.gov/std/hpv/stdfact-hpv.htm. New cases of HIV also occur at vastly lower rates than almost every other sexually transmitted disease, most of which have severe health consequences if untreated. hpb; K. Owusu-Edusei, *et. al., The Estimated Direct Medical Cost Of Selected Sexually Transmitted Infections In The United States, 2008,* 40 Sex. Trans. Dis. 197 (2013). According to the CDC, "[a]bout 79 million Americans are currently infected with HPV" and "[a]bout 14 million people become newly infected each year." CDC, *Genital HPV Infection - Fact Sheet*. Hepatitis A, B, and C are "about as common as HIV, but [] easier to transmit."

Buchanan, *When Is HIV a Crime?*, 99 Minn. L. Rev. at 1279, 1279 n.218 (citing CDC statistics). By contrast, just over 1.2 million Americans are infected with HIV, with annual new cases estimated at between 40,000 and 50,000. CDC, *HIV in the United States: At a Glance* (2016), *available at* http://www.cdc.gov/hiv/statistics/overview/ataglance.html. By no means, then, is the uniquely punitive treatment of HIV justified; instead, the Act unjustifiably represents a vestige of the "widespread fear and moral outrage" that attended "the HIV epidemic in the 1980s." Barber & Lichtenstein, *Support for HIV Testing* at 270. This is exactly the kind of "status-based enactment divorced from any factual context from which we could discern a relationship to legitimate state interests" that, under *Romer*, violates equal protection. 517 U.S. at 635.

And people living with HIV are also singled out because the Act imposes a lower *mens rea* requirement, as previously noted. The fact that the Act operates as a strict liability statute, effectively equating knowledge of one's HIV-positive status with intent to harm, is strong evidence of animus. *See* President's Advisory Council on AIDS, *Resolution on Ending Federal and State HIV-Specific Criminal Laws, Prosecutions, and Civil Commitments* ("Legal standards applied in HIV criminalization cases regarding intent, harm, and proportionality deviate from generally accepted criminal law principles and reflect stigma toward HIV and HIV-positive individuals.").

Significantly, other States have begun to recognize that there is no longer a rational basis for differential treatment of HIV in the criminal law. For example, several years ago Illinois modernized its HIV-specific criminal law.[19] While maintaining a statute that irrationally singles

[19] Other jurisdictions have also enacted, and some are considering, reforms that are both more rational and less punitive than Section 2903.11(B)(1). For example, in California, a violation of the applicable law requires a showing of "specific intent to infect," Cal. Health & Saf. Code §

out HIV for criminal regulation, the new code at least addresses the former law's overinclusiveness by limiting coverage to anal and vaginal intercourse "without the use of a condom," while also requiring proof of "specific intent" to infect. 720 Ill. Comp. Stat. Ann. 5/12-5.01 (2014); *see* Buchanan, *When Is HIV a Crime?*, 99 Minn. L. Rev. at 1234 n.15 (discussing legislative history of Illinois amendment). More recently, prosecutors from across the country convened to form an ongoing national roundtable to review the value and fairness of state HIV criminal laws in view of current knowledge about HIV transmission and treatment.[20] The fact that the Association of Prosecuting Attorneys and its members — professionals charged with enforcing laws such as Ohio's HIV criminal law — have joined forces to re-examine laws such as the Act is further evidence of the growing consensus that they irrationally single out people living with HIV without serving the public's interests.

These modernization efforts signal a move towards a more rational approach to legitimate public health concerns; they reflect a shift in focus towards objectively reasonable facts about HIV and away from assumptions and stereotypes. By persisting in "impos[ing] a special disability upon [the classified] persons alone" without basis in objectively reasonable facts, even as other jurisdictions recognize the objective failings and underlying prejudice of these laws, Ohio provides further evidence that animus is at the root of the Act. *Romer*, 517 U.S. at 631.

120291 (2016); in Maryland, a violation provides misdemeanor punishment of up to three years Maryland Health-General Code § 18-601.1. And in Colorado, the legislature amended its statute to cover all sexually transmitted infections and to make transmission, not mere exposure, a necessary element of the offense; the revised statute also significantly reduces the penalty for conviction. Colo. S.B. 16-146, enacted June 6, 2016.

[20] Norman L. Reimer, *Inside NACDL: A Lamentable Example of Overcriminalization: HIV Criminalization*, 37 Champion 7, 7 (December 2013) ("The express purpose of the meeting was to consider the relevance, viability, and fairness of HIV criminalization laws and policies in light of the current science about HIV transmission and treatment. Much of the convening was devoted to review of that science in an effort to separate facts from myths — myths that have resulted in the enactment of laws that bear no relationship to reality and that have stigmatized HIV-positive individuals for more than a quarter of a century.").

These considerations support the inference that inevitably arises from the Act's lack of rational grounding, promotion of stigma, and counterproductive effect on public health: that the Act's continued existence reflects discrimination not only against people living with HIV and AIDS, but also against those most affected by HIV and AIDS today – poor blacks. In sum, the Act is an arbitrary law that serves no purpose but to further harm a group that is already subject to societal discrimination on grounds of little more than fear and animus. For these reasons, the Act is unconstitutional, and Mr. Batista's sentence cannot stand.

III. Proposition of Law Number Two: The Act Violates Prohibitions Against Discrimination on the Basis of Disability.

Section 2903.11(B)(1) also violates the clear prohibitions against disability-based discrimination under the Americans with Disabilities Act ("ADA")[21] and Section 504 of the Rehabilitation Act ("Section 504").[22] That is because the Act singles out people living with HIV for unique – and uniquely onerous – punishment for otherwise legal conduct based on their HIV status and scientifically unsupportable beliefs about HIV.

Title II of the ADA ("Title II") and Section 504 both prohibit discrimination on the basis of disability: Title II applies to the activities of public entities, while Section 504 governs recipients of federal funding, including state agencies. 42 U.S.C. §§ 12131, 12132, 28 C.F.R. § 35.130 (2016); 29 U.S.C. § 794(a). To succeed on a claim that State action violates Title II, a litigant must establish that (1) he has a "disability" as defined by the ADA; (2) he is "otherwise qualified" to be free of the contested State action; and (3) the contested State action was taken against the litigant because of his protected disability. *See, e.g., Randolph v. Rogers*, 170 F.3d 850, 858 (8th Cir. 1999); *Wolfe v. Ohio Dep't. of Rehab. & Corr.*, 10th Dist. Franklin No. 11AP-

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[21] 42 USC §§12131,12132; 28 C.F.R. 35.130 (2016).

[22] 29 U.S.C. § 701 *et seq.* (2014).

346, 2011 WL 6931479, at *4 (10th Dist. Dec. 30, 2011). A claim under Section 504 requires proof of these same three elements, plus an additional one: that the contested State action was performed by an agency that receives federal funding. *See, e.g., Harris v. Thigpen*, 941 F.2d 1495, 1522 (11th Cir. 1991); *Doe v. Adkins*, 110 Ohio App.3d 427, 433 (4th Dist. 1996).

As a preliminary matter, Title II of the ADA is sufficiently broad to cover State criminal regulations and their enforcement. Title II's protections include activities of the legislative and judicial branches of State and local governments, 28 C.F.R. § 35.102 (a) (2016); 28 C.F.R. § 35.104, and while it does not expressly identify state legislative activity as within its scope, "[t]he fact that the statute can be 'applied in situations not expressly anticipated by Congress does not demonstrate ambiguity. It demonstrates breadth'." *Gorman v. Bartch*, 152 F.3d 907, 912 (8th 1998) (quoting *Pa. Dep't. of Corrs. v. Yeskey*, 524 U.S. 206, 212 (1998)). Thus, the U.S. Department of Justice, whose interpretation of Titles I and II of the ADA is entitled to appropriate deference, *see Bragdon v. Abbott*, 524 U.S. 624, 646 (1998), has made it clear that "[a]ll activities, services, and programs of public entities are covered, *including activities of State legislatures* and courts, town meetings, police and fire departments, motor vehicle licensing, and employment." U.S. Dep't of Justice, *Title II Highlights* (emphasis added), *available at* http://www.ada.gov/t2hlt95.htm. In addition, several United States Courts of Appeals have held State legislatures to be public entities subject to Title II's requirements. *See, e.g.*, *Klingler v. Director, Dep't of Revenue, Missouri*, 433 F.3d 1078, 1080 (8th Cir. 2006); *Hargrave v. Vermont*, 340 F.3d 27 (2d Cir. 2003); *Bay Area Addiction Research and Treatment, Inc. v. City of Antioch*, 179 F.3d 725 (9th Cir. 1999); *Peck v. Clayton County,* 47 F.3d 430 (11th Cir. 1995). Furthermore, Title II and Section 504 apply equally when the contested State activity pertains to criminal law enforcement. *See*, *e.g.*, *Davis v. Thompson*, 295 F.3d 890, 897 (9th Cir. 2002) ("A

state's substantive decision-making processes in the criminal law context are not immune from the anti-discrimination guarantees of federal statutory law"); *Gohier v. Enright*, 186 F.3d 1216, 1221 (10th Cir. 1999) (under ADA regulations, "law enforcement is obligated to modify 'policies that result in discriminatory arrests or abuse of individuals with disabilities.'") (internal citations omitted).

The ADA defines "disability," the first element of a claim under Title II and Section 504 as:

> (a) a physical or mental impairment that substantially limits one or more major life activities . . . ;
>
> (b) a record of such an impairment; or
>
> (c) being regarded as having such an impairment[.]

42 U.S.C. § 12102(1)(A).[23] Congress dispensed with any doubts as to whether HIV is a protected disability when it passed the ADA Amendments Act of 2008 (ADAAA) (noting that the newly enacted definition should be broadly construed and adding physical functions directly affecting HIV to examples of affected life activities relevant to disability definition);[24] and the U.S. Department of Justice, Civil Rights Division has likewise confirmed that HIV is a protected disability under federal antidiscrimination law.[25] Moreover, as the United States Supreme Court made clear in its decision in *School Board of Nassau County v. Arline*, the "regarded as" language of the statute is designed to incorporate individuals who have a condition that triggers the prejudice and discriminatory reactions and perceptions of others:

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[23] *See also* 42 U.S.C. § 12102(2)(B) (including functions of the immune system in illustrative list of life activities the impairment of which is relevant to determining that an individual's disability is covered under the ADA).

[24] Americans with Disabilities Act Amendments Act, Pub.L. No. 110-325, 122 Stat. (2008) 3553; H.R. Rep. No. 110-730, 110th Cong., 2d Sess. (2008).

[25] *See* http://www.ada.gov/aids/index.htm.; 28 C.F.R. § 35.104(i)(ii); 42 U.S.C. § 12134; 28 C.F.R. § 35.190(b)(6).

> By amending the definition of "handicapped individual" to include not only those who are actually physically impaired, but also those who are regarded as impaired … Congress acknowledged that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment. Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness.

480 U.S. at 284. *Arline* thus acknowledged both that the "regarded as" prong of the ADA definition of disability includes those whose conditions result in public prejudice and that contagious diseases are subject to prejudice of exactly this type. *Id.* Numerous cases have since confirmed that because of the continuing scourge of HIV discrimination in all aspects of private and public settings and institutions, Section 504 and Title II of the ADA protect people living with HIV and AIDS. *See, e.g.*, *Holiday v. City of Chattanooga*, 206 F.3d 637 (6th Cir. 2000); *Chalk v. U.S. Dist. Ct. of Cent. Dist. of California,* 840 F.2d 701 (9th Cir. 1988); *Henderson v. Thomas*, 913 F.Supp.2d 1267 (M.D. Alabama 2012).

The second element of a claim under Section 504 and Title II concerns whether the claimant is "otherwise qualified" to be free of the State activity that is the focus of the discriminatory treatment. *Thigpen,* 941 F.2d. at 1522. The question here is whether individuals living with HIV are "otherwise qualified" to have intimate sexual relationships and engage in other conduct proscribed under the Act on the same terms as all other individuals without the disability of HIV. In *Arline*, the Supreme Court held that in the context of a communicable disease, the "otherwise qualified" inquiry must consider:

> (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long the carrier is infected), the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.

480 U.S. at 288.

Application of these factors ultimately turns on the principle that "the significance of a risk is a product of the odds that transmission will occur and the severity of the consequences." *Id.* The Supreme Court emphasized in *Arline* that if a policy doesn't provide for application of these factors on an individualized, case by case basis, it contravenes the goal of Section 504 "of protecting handicapped [sic] individuals from deprivations based on prejudice, stereotypes, or unfounded fear [.]" *Id.* at 287.[26]

As discussed at length above, there can be no question that people living with HIV are otherwise qualified to engage in sexual activity without being subject to criminal prosecution for the nondisclosure of their HIV status.[27] The Act criminalizes much conduct that has little or no risk of HIV transmission, including oral sex, sex with condoms, or sex with an individual whose

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[26] In rejecting an earlier Eleventh Circuit decision that upheld the segregation of inmates with HIV on the basis that they posed a threat to others' safety and therefore fell outside the ADA's protections, the district court in *Henderson* found it dispositive that, while the Eleventh Circuit had based its conclusion on "'the state of medical knowledge and art at the time of trial,'" *Henderson*, 913 F.Supp.2d at 1290 (internal citation omitted), "[t]oday, however, HIV does not invariably cause death [and]]t]he vast majority of infected individuals can expect to live a near-normal lifespan." *Id.*

[27] As *Amici* establish above, even without treatment, HIV is not easily transmitted, and many couples have remained, even before the advent of PrEP, in sero-discordant relationships for years without the HIV-negative partner becoming infected. In addition to PrEP, post-exposure prophylaxis, or PEP, is available to reduce transmission risks following contact where a prevention measure may have failed or been neglected. Roland M.E., *et al.*, *Seroconversion Following Nonoccupational Postexposure Prophylaxis Against HIV*, 41 Clin. Infect. Dis. 1507 (2005). Not surprisingly, people living with HIV are encouraged to have healthy, loving relationships, even to have children if that is their choice, *see* CDC, *HIV Among Pregnant Women, Infants, and Children*, *available at* http://www.cdc.gov/hiv/group/gender/pregnantwomen/index.html; U.S. Dep't. of Health & Human Servs. Panel on Treatment of HIV-Infected Pregnant Women & Prevention of Perinatal Transmission, *Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States*, *available at* https://aidsinfo.nih.gov/contentfiles/lvguidelines/perinatalgl.pdf (last updated Aug. 6, 2015); U.S. Dep't of Health & Human Servs., *Pregnancy and Childbirth*, *available at* https://www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/pregnancy-and-childbirth/ (last updated Sept. 28, 2015); and interventions to prevent mother-to-child transmission have, since their discovery more than 20 years ago, practically eliminated pediatric HIV transmission in this country.

viral load is undetectable. By virtue of its sweeping, overinclusive nature, the Act thus concerns individuals with a protected disability who are "otherwise qualified" within the meaning of Title II, as interpreted by *Arline*.

The third element to a claim under Title II and Section 504 is whether the claimant's disability, and discriminatory attitudes about that disability, are the reason for the contested State action. In analyzing under this element, courts often look to whether the State activity is based on unfounded stereotypes. This, too, has been discussed at length above: HIV specific criminal laws are the product of historical and ongoing animus. Regardless of the Act's original intent, its terms reflect precisely the types of persistent, intractable stereotypes — misinformation about transmission, assumptions about dangerousness and irreparable outcomes — that trigger Court intervention under the ADA.

Finally, to succeed under Section 504, a claimant must establish that the challenged State body receives federal funding. In 1990, the United States Congress enacted the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act, Public Law 101-381, *codified at* 42 U.S.C. § 300ff *et seq.*, which required States to certify that their criminal laws are sufficient to prosecute HIV-infected persons who knowingly expose others to HIV infection in order to receive funding for HIV/AIDS treatment and care, *id.* at § 300ff-47 (2000). Ohio has, of course, so certified. *See* Univ. of California San Francisco Center for AIDS Prevention Studies, *is there a role for criminal law in HIV prevention?* (2005), *available at* http://caps.ucsf.edu/uploads/pubs/FS/pdf/criminalizationFS.pdf (by 2000, all 50 States had certified compliance to the federal government). Accordingly, the fourth and final element of a claim under Section 504 is established.

In sum, the Act, applies a special requirement for individuals with HIV that is precisely the kind prohibited under ADA regulations. *See* 28 C.F.R. § 35.130(b)(8). When people with a protected disability are subjected to illogical requirements under threat of criminal prosecution for the simple reason of widespread prejudice, the authorizing criminal statute is in violation of Title II and, as here, Section 504.

IV. Conclusion

For all of the foregoing reasons, undersigned *amici* respectfully submit that this Court should vacate Mr. Batista's sentence. Approximately 16 years after passage of Section 2903.11(B)(1), and more than 30 since the outbreak of HIV and AIDS in this country, there is no longer any rational justification for HIV-specific criminal laws. Because these laws now serve only to ostracize politically unpopular groups, even as they undermine rather than promote legitimate public health goals, and run afoul of federal laws, they are invalid and the Court should accordingly invalidate the Act, reverse Mr. Batista's conviction, and vacate his sentence.

Respectfully submitted

/s/: *Valerie Kunze*
Valerie Kunze (0086927)

Dated: December 27, 2016

Certificate of Service and Compliance

I certify that a copy of this Brief of *Amici Curiae* on Behalf of Appellant Orlando Batista has been served on:

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(2) Raymond T. Faller, Joshua A. Thompson, and Demetra Stamakos, Counsel for Appellant, Orlando Batista, at 230 East Ninth Street, Second Floor, Cincinnati, Ohio 45202

by regular U.S. Mail on this 27th day of December, 2016.

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