



The Center for Law & the Public's Health
at Georgetown & Johns Hopkins Universities
CDC Collaborating Center Promoting Health through Law

ADVANCING HIV PREVENTION INITIATIVE -
**A LIMITED LEGAL ANALYSIS OF STATE HIV
STATUTES**

Initial Assessment for the Centers for Disease Control and Prevention

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1.0 BRIEF INTRODUCTION

Significant progress in the control of HIV/AIDS in the United States has been made in recent years through prevention programs and other public health outreach measures. However, an estimated 40,000 new HIV infections still occur in the United States each year. Though AIDS mortality rates have substantially declined due to improved treatment options, the number of people living with HIV/AIDS is steadily increasing. The Centers for Disease Control and Prevention (CDC) estimates that 850,000 to 950,000 people in the United States are currently living with HIV. At least one-fourth of those infected are believed to be unaware of their status. Approximately two-thirds of new infections may be unknowingly caused by these individuals, as most people who are aware of their HIV status take precautions to reduce the chance of transmission.¹

To address the changing nature of HIV transmissions in the United States and in an effort to identify HIV-infected individuals who have not been tested, CDC launched a new initiative, “*Advancing HIV Prevention (AHP): New Strategies for a Changing Epidemic*” in April 2003. The intent of the AHP initiative is to identify HIV-infected individuals unaware of their status and provide these individuals with prevention services and treatment. Through the efforts of federal, state, and local and public health officials and their partners, CDC posits that HIV incidence may be reduced. The *AHP Initiative* consists of activities within four major strategies:²

1. Make HIV testing a routine part of medical care;
 2. Implement new models for diagnosing HIV infections outside medical settings;
 3. Prevent new infections by working with people diagnosed with HIV and their partners;
- and

4. Further decrease perinatal HIV transmission.

From the onset of the AHP Initiative, CDC recognized the potential for existing state laws to impact the performance of multiple activities pursuant to these strategies. It specifically sought to identify state legislation that could support or hinder these strategies. CDC asked the National Conference of State Legislatures (NCSL) to research relevant state statutes across the fifty (50) states. NCSL provided CDC with a series of tables and accompanying state statutes that were pre-identified as relevant to AHP strategies. CDC then requested the *Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities* to conduct an initial analysis of these identified statutory provisions, including explanation of the ways that specific state HIV laws may impact the strategies of the AHP Initiative in individual states.³ The *Center's* analysis is exclusively focused on the state statutory laws researched by NCSL. Additional legal research on additional laws, including constitutional provisions, statutes, regulations, judicial case law, and public health practices at the federal and state levels is needed to comprehensively assess the legal environment for conducting the goals of the AHP Initiative.⁴

NCSL's series of tables (and accompanying statutes) organized state legislative provisions within twenty (20) different categories based on pre-identified legal issues (see Table 1 in Section 2.0 for a listing of these categories). To simplify the analysis of these findings, this report groups NCSL's tables and corresponding statutes into four (4) major areas of HIV/AIDS laws concerning: (1) Personnel; (2) Pre-test Requirements; (3) Testing; and (4) Post-test Requirements. These categories and relevant laws are discussed in detail in Section 2.0 and Table 1. Additional information regarding state statutes is provided in Table 2.

Section 3.0 discusses the potential impact of state HIV statutes within each of the strategies of the AHP Initiative. Some state HIV statutes identified by NCSL facilitate the

performance of CDC's AHP strategies. For example, most states allow health care providers (e.g., physicians, nurses) to order and perform HIV tests and to provide pre-test counseling without additional certification or training. Furthermore, state statutes currently encourage HIV risk management and partner counseling and referral services in conjunction with HIV testing. Other state statutes, however, present potential barriers to effective implementation. These laws may restrict the type of testing allowed, require expensive training or certification to perform testing or counseling, or restrict the delivery of test results. NCSL's statutory research does not specifically address AHP's fourth strategy—further decreasing mother-to-child HIV transmission. However, legislation in many states currently regulates prenatal and newborn HIV testing. A brief discussion of these statutes and potential consequences of incorporating HIV testing into routine prenatal care concludes Section 3.0.

2.0 MAJOR CATEGORIES OF STATE HIV TESTING LAWS

NCSL identified state HIV statutes based on twenty (20) legal issues that it developed with CDC guidance. These issues focus on areas of state legislation that are perceived as capable of supporting or hindering CDC's AHP Initiative. This report closely examines seventeen (17) of these issues and their corresponding statutes. Three (3) of the issues identified for research by NCSL [(1) prohibition of opt-out consent forms, (2) requirements or regulations in addition to those of Clinical Laboratory Improvement Amendment Act (CLIA) that preclude or restrict the use of a rapid HIV test, and (3) restrictions on who can offer prevention case management (PCM)] did not produce any relevant state statutes. To facilitate the review of these statutes, this report groups these issues into four (4) major categories: (1) Personnel; (2) Pre-test Requirements; (3) Testing; and (4) Post-test Requirements. The various types of state HIV legislation within each of these major categories are described and analyzed in the sections below. Table 2, featured at the end of this section, provides a comprehensive summary of state HIV statutes by major category, and is consistently referenced in the sections below. Please refer to Table 2 for specific data (in many cases) on those states that feature HIV legislation for the identified categories.

Table 1 - NCSL Legal Issues and Corresponding Categories

Legislative Issues Addressed by NCSL	Organizational Category within Report
1. Limitations on who can request testing, including parental consent and parental notification	Pre-test requirements
2. Requirements and stipulations for pre-test counseling	Pre-test requirements
3. Requirements for specific information that must be provided before testing	Pre-test requirements
4. Requirements for written consent specific for HIV testing	Pre-test requirements
5. Prohibition of "opt out" consent forms	N/A
6. Stipulations on who can offer HIV counseling and/or testing services	Personnel
7. Requirements mandating anonymous HIV testing	Testing
8. Training certification and other requirements for persons who counsel individuals who are tested	Personnel
9. Requirements or restrictions for HIV testing in addition to those of CLIA	Testing
10. Requirements or regulations in addition to those of CLIA that preclude or restrict the use of a rapid HIV test	N/A
11. Mandatory HIV testing of certain individuals charged with sex-related crimes	Testing
12. Mandatory HIV testing as part of a hiring/fitness process.	Testing
13. Laws encouraging prosecution of HIV-positive persons who have willfully exposed others	Post-test requirements
14. Limitations on ability of governmental educational or correctional systems to offer HIV testing	Testing
15. Requirements to use specific types of antibody and confirmatory tests	Testing; Post-test requirements
16. Requirements to complete a confirmed test regime before releasing preliminary results	Post-test requirements
17. Requirements for confirmation testing in a state health department laboratory	Post-test requirements
18. Requirements that test results can only be given, face to face, by specifically trained counselors	Post-test requirements
19. Restrictions on who can offer partner counseling and referral services (PCRS)	Personnel
20. Restrictions on who can offer prevention case management services (PCM)	N/A

2.1 Personnel.

A majority of states regulate the personnel who can offer HIV counseling and testing. At least forty (40) states (see Table 2.1(A)) have enacted legislation in this area, often limiting who can provide testing and counseling to include (1) trained health care providers (e.g., physicians, nurses, emergency medical technicians), and (2) government employees in state departments of health or corrections. These limitations vary greatly among states. Some specifically regulate the withdrawal of blood for HIV testing. For example, California limits the ability to draw blood for HIV testing to physicians, registered nurses, licensed medical technicians, and phlebotomists.⁵ Other states legislate criteria necessary for ordering HIV tests. Georgia extends the power to order HIV testing to funeral directors, nursing home administrators, midwives, dentists, and psychologists, in addition to physicians, nurses and emergency medical

technicians.⁶ Some states restrict who can offer HIV testing and counseling in specific cases, such as convictions for a sex-related crime. Finally, many states broadly regulate the actions of a physician or health care provider who requests an HIV test even if they do not impose specific requirements pertaining to the testing process itself (for more information on laws specifically related to HIV testing, see section 2.3 below, and Table 2.3 (A-H)).

Most states also regulate individuals providing pre- and post-test HIV counseling. Many states require pre- and/or post-test counseling when an HIV test is administered.. A majority of states (see Table 2.1(B)) limits the ability to provide such counseling to health care providers, such as physicians or nurses, community-based organizations and others, who have been trained according to specific state requirements, although jurisdiction-specific research is needed to properly assess these limitations. For example, NCSL's research did not examine whether social workers or other licensed counselors may provide counseling.

Seven (7) states (CA, CT, FL, KY, LA, OH, TX) have very specific training and certification requirements for any HIV counselor. Kentucky mandates that each health care professional licensing board or certifying entity implement an HIV/AIDS education program for certification purposes. All health care workers and social workers must complete courses to obtain certification.⁷ Similarly, Ohio requires the state health director to develop and administer HIV/AIDS counseling training programs for all health care providers.⁸ California requires the establishment of community-based training programs utilizing a curriculum approved by the state health department for any counselor involved in publicly funded HIV testing programs.⁹ Despite the requirement for counseling in most states, few states statutorily specify the content of the counseling itself, leaving this largely to administrative rulemaking or internal public health policies.

Thirty-two (32) states (see Table 2.1(C)) have also regulated those who provide HIV partner counseling and referral services (PCRS) (a.k.a. partner notification). States typically restrict the types of persons who can offer PCRS to physicians and health department employees. According to NCSL, six states (AZ, CA, ID, LA, OK, WI) allow other individuals or organizations to offer PCRS. Statutes allow physicians and health officers to notify third parties of positive HIV test results where there is a foreseeable or probable risk of transmission. States may also require the provision of counseling and free testing to any individual at risk for infection. For example, Connecticut allows a public health officer or physician to inform partners of an HIV-positive individual if (1) there is a significant risk of transmission and (2) the individual has been counseled regarding notification. After disclosing the risk, the partner must also be offered medical advice and counseling. Only public health officials and physicians are allowed to disclose information to partners.¹⁰

2.2 Pre-test Requirements.

Nearly every state regulates pre-test activities concerning HIV testing. Many states (see Table 2.2(A)) require pre-test counseling and the provision of specific information on the test itself, as well as risks associated with HIV/AIDS. These statutes typically apply to anyone seeking HIV testing. Some states have also enacted additional requirements when testing specific subsets of the population, such as pregnant women (IN, IA, MD, NJ, RI, TN), substance abusers (IA), and convicted sex offenders (IN, IA, MD, NV, RI). Typical pre-test requirements include: (1) an explanation of the test, its potential uses and its limitations; (2) an assurance of confidentiality; (3) an explanation of HIV transmission, symptoms associated with HIV/AIDS, and treatment options; and (4) a disclosure of results.

These requirements are usually embodied in state informed consent laws related to HIV-testing. For example, Delaware necessitates individual informed consent prior to any HIV-related testing. Informed consent must include an explanation of the test, the medical procedure, the nature of HIV/AIDS, and information about risk management and reduction.¹¹ Similarly, Maryland requires all health care providers to offer pre-test counseling, including HIV education, information about the duty to warn, and assistance in accessing appropriate care.¹²

Of course, most state statutes requiring pre-test counseling also require some level of informed consent. Thirty-one (31) states and the District of Columbia (see Table 2.2(B)) require informed consent. These laws often mandate that health care providers or facilities obtain written informed consent prior to performing HIV testing or disclosing results. California's statute is typical: "no person shall test a person's blood for evidence of antibodies to the probable causative agent of AIDS without the written consent of the subject of the test."¹³ Montana, New Hampshire, and New Mexico require informed consent but do not specify whether the consent should be written or oral. Connecticut and Texas allow either written or oral consent. The remaining 26 states and the District of Columbia (see Table 2.2(B)) require written consent. Additionally, a small number of states compel written informed consent for specific testing circumstances, including testing for insurance purposes (DC, DE, FL, NY, OH, VT, WA), testing of organ, tissue, blood and semen donors (KY, MD, NJ), and testing of pregnant women (TN).

Twenty-four (24) states (see Table 2.2(C)) have enacted additional regulations regarding requests for HIV testing pursuant to sex-related crimes. An accused sex offender can often be compelled to submit to HIV testing at the request of the court, the state, the victim, or the victim's parent or guardian. Testing may also be allowed at the request of a minor offender's

parent or guardian (though this is rare). Florida offers different requirements for the testing of sex offenders. First, upon release from detention, any individual convicted of a crime involving sexual contact must submit to an HIV test, and the results must be released to the victim.¹⁴ Additionally, at the request of the victim of a sex crime, or victim's legal guardian, the court must order the individual charged with the offense to undergo future HIV testing. The results again must be released to the victim in a timely manner.¹⁵

Whenever HIV testing is performed in a sex-related criminal case, counseling must be offered to the victim and the offender in most states, if the test results are positive. Some states also require parental notification of HIV testing and the test results, if either the victim or the offender is a minor. Florida necessitates parental notification to parents of a minor victim or a minor offender, and also requires timely face-to-face counseling for the victim in the event of a positive test result.¹⁶ Similarly, Delaware mandates that its Division of Public Health provide HIV counseling to the victim and the defendant, and also requires a referral for necessary health care and other support services.¹⁷

A final area of pre-test requirements specifically concerns HIV testing of minors. Eight states impose age requirements to authorize testing, (CA, CT, IL, MT, NY, NC, ND, OH) and parental notification requirements. All of these states (except NC and OH) require prior parental authorization. Ohio allows a minor to provide his or her own consent and does not set forth an age limit.¹⁸ North Carolina allows a minor to be tested if parental consent is refused and there is a reasonable suspicion that the minor has been exposed to HIV.¹⁹

2.3 *Testing.*

Of the state statutes that address HIV testing itself, most focus on the type of testing regime that must be employed. For example, Hawaii sets forth quality assurance standards for

HIV testing. Any laboratory performing HIV antibody tests in Hawaii must: (1) use Food and Drug Administration (FDA) approved screening tests, (2) confirm an initial positive result with a second screening test, and (3) confirm two positive screening results with a Western Blot or an Immunofluorescence Assay.²⁰ Colorado requires a minimum test protocol including two positive enzyme-linked immunosorbent assay (ELISA) tests and a positive Western Blot test, or an equally stringent protocol that has received approval from the state public health department.²¹ In all, fifteen (15) states require that a specific type of test be used, twelve (12) states require a confirmatory test, twelve (12) states require the use of a Western Blot, and ten (10) states require the use of an ELISA test in screening for HIV (see Table 2.3). Most states that have imposed test regime requirements also mandate that the regime must be completed before positive test results can be released. States' laws concerning this requirement vary extensively. Specific assessment of each state's law is essential to assess the circumstances in which confirmatory testing is required before results are reported.

The use of rapid HIV tests has been encouraged in recent years due to their ability to screen accurately for HIV within a short time period. Only clinical laboratories (a facility performing human examinations) and labs with higher-level CLIA certificates can purchase and perform rapid tests.²² According to NCSL's research, a few states (NY, NC, WA) statutorily impose requirements for HIV testing in addition to those required by CLIA. CDC suggests that additional states (e.g. MD, NJ, TN) follow similar legal requirements, although these are not reflected in NCSL's research. For example, in New York, (which, like WA, is exempt from adhering to CLIA requirements, the state Department of Public Health is authorized to adopt guidelines stricter than the requirements established by CLIA.²³

Currently, only two states (CA and OK) statutorily allow the use of rapid HIV tests. Rapid testing in Oklahoma is only authorized to test individuals charged with a sex-related crime. The use of rapid HIV tests is also statutorily encouraged in Illinois.²⁴ Many other states promote the use of rapid HIV tests through their administrative codes or state public health agencies, including New York,²⁵ New Jersey, and Tennessee, but do not statutorily mention rapid HIV testing. Additional research (beyond NCSL's statutory review) is needed to fully assess the nature of state legal support for rapid HIV tests.

Most states (see Table 2.3(E)) also require that anonymous HIV testing be available as an option. This requirement is typically embodied in the standards established by states for pre-test counseling or informed consent. For example, Louisiana mandates that a person requesting an HIV test "shall be provided an opportunity to remain anonymous by the use of a coded system."²⁶ Maine has established anonymous HIV testing sites, which are regulated by its Department of Human Services.²⁷ Eight (8) states (CA, CT, DE, IL, NH, NC, PA, WI) specifically delineate requirements for unlinked anonymous testing for research purposes. These statutes largely focus on testing "for the purpose of research if the testing is performed in a manner by which the identity of the test subject is not known and is unable to be retrieved by the researcher."²⁸

A final, major area of state legislation related to HIV testing involves mandatory testing of individuals charged with specific sex-related crimes, regardless of whether the victim requests that testing be performed. Forty-five (45) states and the District of Columbia have enacted statutes concerning such testing, and nineteen (19) states mandate testing once probable cause has been demonstrated or upon conviction (see Table 2.3(F)). For example, Alabama requires any person sentenced to confinement or imprisonment for more than thirty (30) days to be tested

for an array of sexually-transmitted diseases, including HIV, regardless of the nature of the crime. In the case of a sexual offense, any HIV test results must be reported to a state health officer, and the test results must be released to the victim upon request.²⁹ California mandates that every person convicted of a sex offense submit to an HIV antibody test within 180 days of the conviction date.³⁰

Other states require testing at the request of the victim of a sex offense, or upon request of the court. In Iowa, a victim may petition the court for an order requiring a convicted sex offender to submit to an HIV test, if the victim can demonstrate that significant sexual exposure occurred.³¹ Minnesota allows testing upon the victim's request if the crime involved sexual penetration or if significant sexual exposure can be demonstrated.³² Twenty-five (25) states (see Table 2.3(G)) that require HIV testing for sexual offenses also require the provision of HIV testing and PCRS to the victim in the event of a positive test. Four of these states (DC, MI, OR, SC) also call specifically for HIV counseling to be provided to a defendant who has tested positive.

Finally, a few states address additional issues surrounding HIV testing. Kentucky prohibits any person from requiring an HIV test as a condition of employment unless there is a bona fide reason for HIV testing. The burden of proof lies with the person requiring the test.³³ Kentucky and Maine are the only states that prohibit mandatory HIV testing as part of a hiring process.³⁴ In addition, Vermont and Texas regulate HIV testing at educational institutions. Vermont prohibits any educational institution from requiring an applicant or prospective student to submit to an HIV test.³⁵ Texas has attempted to promote HIV education and awareness in higher educational institutions by requiring student health centers to provide information on HIV prevention and transmission, and to promote testing and counseling services.³⁶

2.4 Post-test Requirements.

Most state legislation regulating post-test activities relates to confirmatory testing and the delivery of test results (see Table 2). Some states require that confirmatory testing be performed in a licensed state health department laboratory (see Table 2.4(A)). Twelve (12) states require that a confirmatory test regime, including a repeat ELISA test and the use of a confirmatory Western Blot or other FDA-approved test, must be completed before positive results can be released to the patient (see Table 2.3(B)). According to NCSL, a few states (AL, FL, IL, ME, PA, TX) have also enacted specific post-test counseling requirements, mandating education and partner notification, regardless of the test result. These states also require that test results be given, face-to-face, by trained HIV counselors, in addition to mandating post-test counseling itself. For example, Maine defines pre-test counseling as “face-to-face counseling” and requires the offer of direct interaction during post-test counseling.³⁷ Alabama mandates that a physician or the state public health department notify any person who has tested positive for HIV and provide face-to-face post-test counseling and risk management.³⁸

If an individual tests positive for HIV and is determined to have "willfully exposed" others to potential infection, many states allow for criminal prosecution. At least thirty-three (33) states have enacted statutes regarding willful exposure (see Table 2.4(B)). Some of these statutes are HIV-specific; others pertain to all sexually-transmitted diseases. Some states define "exposure" broadly so as to not limit potential modes of transmission. Other states specify sexual activity, blood donations, needle sharing and prostitution as possible means of exposure. For example, Georgia states that the transmission of bodily fluids by a person knowingly infected with HIV through sexual intercourse or other sexual acts, needle sharing, prostitution, solicitation, or blood or organ donation is a felony.³⁹ Alternatively, New York asserts that any

individual who knowingly has an infectious venereal disease and has sexual intercourse with another person is guilty of a misdemeanor.⁴⁰ In sum, most states classify willful exposure as either a felony or misdemeanor and allow prosecution of willful exposure through, at a minimum, sexual activity.

Table 2 – Comprehensive Summary of State HIV Statutes by Major Category

Organizational Category	Type of Statute	States with Applicable Statutes	Total
2.1 Personnel	<i>A. Statutes regulating who can offer HIV testing.</i> These states stipulate who can offer HIV testing. Analysis is limited to: physicians, physician assistants, RNs, LPNs, EMTs, CBOs, Prenatal Care Providers, Dept. of Corrections, and Dept. of Health agents	AK, CA, CT, FL, HI, GA, IA, IL, IN, KY, LA, ME, MD, MI, MN, MS, MO, MT, NE, NJ, NY, NC, ND, NH, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	40
	<i>B. Statutes regulating who can offer HIV counseling</i> These states stipulate who can offer HIV counseling. Analysis is limited to: physicians, physician assistants, RNs, LPNs, EMTs, CBOs, Prenatal Care Providers, Dept. of Corrections, and Dept. of Health agents.	CA, CT, FL, GA, IA, IL, IN, KY, ME, MD, MI, MN, MS, MO, NE, NJ, NC, ND, OH, PA, RI, SC, SD, TN, UT, VT, VA, WI, WY	29
	<i>C. Statutes restricting who can offer PCRS</i> These states stipulate who can offer PCRS. Analysis is limited to: physicians, Dept. of Health agents, non-profit organizations, municipalities, faith-based organizations, parole officers, administrative bodies, approved treatment facilities, and public agencies.	AK, AL, AZ, AR, CA, CO, CT, FL, GA, HI, ID, IL, IN, IA, KS, LA, ME, MD, MI, MN, MS, MO, MT, NH, NY, OK, PA, RI, TX, UT, WI, WY	32
2.2 Pre-test Requirements	<i>A. Statutes requiring pre-test counseling and the provision of specific information before testing</i>	CO, CT, DE, DC, FL, GA, IL, IN, IA, KY, LA, ME, MD, MI, NJ, NY, NC, ND, OH, PA, RI, TN, VT, WA	24
	<i>B. Statutes requiring informed consent before testing</i>	Written: AL, AZ, CA, CO, DE, DC, FL, HI, IL, KY, LA, ME, MD, MA, MI, NJ, NY, ND, OH, OR, PA, RI, TN, VT, WA, WV, WI Written or Verbal: CT, TX Do not specify: MT, NH, NM	27 2 3
	<i>C. Statutes regarding requests for HIV testing pursuant to sex crimes</i> These statutes were identified in response to a question regarding the HIV testing of minors. Most statutes that regulate the HIV testing of minors are related to sex crimes.	AK, AZ, CA, DE, FL, GA, ID, IL, IN, IA, KS, LA, MN, MS, MT, NJ, OR, PA, SC, SD, TN, TX, UT, WI	24
	<i>D. Statutes regulating HIV testing of minors</i> These statutes specifically address the testing of minors.	CA, CT, IL, MT, NY, NC, ND, OH	8

Organizational Category	Type of Statute	States with Applicable Statutes	Total
2.3 Testing	<i>A. Statutes requiring the use of a specific HIV test</i>	AL, AR, CA, CO, DE, FL, HI, IL, KY, LA, MI, MO, MT, UT, VT	15
	<i>B. Statutes requiring a confirmatory test</i>	AR, CA, DE, HI, IL, KY, LA, MI, MO, OK, UT, VT	12
	<i>C. Statutes requiring a Western Blot test</i>	AL, AR, CA, CO, DE, HI, IL, LA, MI, MT, UT, VT	12
	<i>D. Statutes requiring an ELISA test</i>	AR, CA, CO, DE, FL, IL, MI, MO, MT, VT	10
	<i>E. Statutes requiring that anonymous testing is available as an option</i> No states mandate anonymous testing as a sole option. These statutes require the availability of anonymous testing for the general public, or for research purposes.	AZ, AR, CA, CO, CT, DE, FL, IL, IN, KS, KY, LA, ME, MI, MO, MT, NH, NJ, NY, NC, OH, PA, SC, TX, UT, WA, WV, WI	28
	<i>F. Statutes concerning HIV testing of individuals charged with sex crimes</i>	AL, AK, AZ, AR, CA, CO, CT, DE, DC, FL, GA, ID, IL, IN, IA, KS, KY, LA, ME, MD, MI, MN, MS, MO, MT, NE, NV, NJ, NY, NC, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY	46
	<i>G. Statutes requiring PCR for victim and/or defendant of a sex crime</i>	AK, AR, CA, DC, ID, IL, IA, LA, ME, MI, MS, MT, NE, NJ, NC, OR, PA, RI, SC, SD, UT, VT, VA, WA, WV	25
	<i>H. Statutes regulating prenatal HIV testing</i>	AK, CA, CT, FL, IN, IA, KY, LA, MD, MI, NJ, NY, RI, TN, TX, VA, WA	17
2.4 Post-test Requirements	<i>A. Statutes requiring that confirmatory testing be performed in a state health department laboratory</i>	AL, DE, IL, MI, MO, UT	6
	<i>B. Statutes regarding willful exposure</i>	AL, AR, CA, CO, CT, FL, GA, ID, IL, IN, IA, KS, KY, LA, MD, MI, MN, MO, MT, NV, NJ, NY, ND, OH, OK, PA, SC, SD, TN, UT, VA, WA, WI	33

3.0 POTENTIAL IMPACT OF STATE HIV STATUTES ON THE AHP INITIATIVE

Consistent with the categorization and analyses of state HIV/AIDS statutes in Section 2.0, this section analyzes the potential or actual impact of these statutes on three⁴¹ of the four AHP Initiative strategies as follows:

3.1 Make HIV testing a routine part of medical care

Some statutorily-imposed requirements and restrictions at the state level have the potential to impact this strategy in the following ways:

3.1(a) Training and Certification Requirements. In all, at least forty (40) states have enacted some form of legislation regulating who can offer HIV testing and counseling (see Table 2). Examples of such legislation are discussed in Section 2.1. However, all state statutes concerning testing allow, at a minimum, physicians and many other health care providers to perform or order testing. These statutes do not impose additional certification requirements on most health providers, and thus are unlikely to hinder the incorporation of HIV testing into routine medical care.

3.1(b) Pre-test Counseling. Many states also impose specific pre-test counseling requirements for all HIV testing (see Section 2.2). Statutes regulating pre-test counseling typically require counselors to provide: (1) an explanation of the test, its potential uses, and its limitations; (2) an assurance of confidentiality; (3) an explanation of HIV transmission and risk management options; and (4) a disclosure of results. Meeting these pre-test counseling requirements would not likely be prohibitive for most health care providers in a routine medical setting. However, seven states (CA,⁴² CT,⁴³ FL,⁴⁴ KY,⁴⁵ LA,⁴⁶ OH,⁴⁷ TX⁴⁸) have very specific training and certification requirements for any individual providing pre-test counseling. These

requirements are discussed in Section 2.1. In these states, providers must undergo additional training before routinely conducting HIV counseling. Additionally, in Florida, Kentucky and Texas, counselors may be required obtain a license from a state authority and complete ongoing professional training to be certified to provide pre-test counseling.

3.1(c) Post-test Counseling. Post-test counseling and statutory requirements for face-to-face notification of test results could pose more of a barrier to HIV testing as a part of routine care. Similar to pre-test counseling, most states require that post-test counselors provide patients with a minimum amount of risk education and management, in addition to partner counseling services. These laws, however, do not specifically regulate who can serve as a counselor and rarely require additional certification or training. Post-test counseling is typically provided upon the delivery of test results, which, with a standard test, occurs approximately seven days after testing. In most of the relevant state statutes, such counseling does not have to be provided face-to-face, and thus impliedly may be provided over the phone when test results are delivered. However, a few states (AL, FL, ME, PA, TX) require that test results be given face-to-face by trained individuals (see Table 3).

Table 3 - Summary of Face-to-Face Counseling Requirements

	Who can deliver results?	What must counseling include?
Alabama	Physician, representative of state Department of Public Health	Meaning of test results; Possible need for additional testing; Need to eliminate risky behavior; Information regarding available and appropriate health care services; Partner referral services
Florida	Physician, representative of the state Department of Health	Meaning of test results; Possible need for additional testing; Need to eliminate risky behavior; Information regarding available and appropriate health care services; Partner referral services
Maine	Physician must offer face-to-face test result delivery and post-test counseling	Meaning of test results; Information on preventive practices; Referrals for medical care and support services
Pennsylvania	Physician or physician's representative must offer face-to-face test result delivery and post-test counseling	Significance of test results; Preventive measures; Benefits of PCRS
Texas	Statute does not specify; however, face-to-	Meaning of test result; Potential need for additional

	face test result delivery must be offered to all individuals	testing; Prevention measures; Benefits of PCRS; Availability of additional health care services
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Such requirements could necessitate additional personnel in a routine care setting, additional office visits from patients (to receive test results in person) in the five (5) states requiring face-to-face exchanges of information, and additional training for any individual providing counseling. Additional research is needed to address other key issues, such as whether state laws allow risk education information to be provided in writing (e.g., though a distributed pamphlet) or require partner counseling after HIV-negative test results.

3.1(d) Informed Consent. Typically, state informed consent laws are embedded in HIV pre-test counseling requirements. Informed consent laws may require that a patient receive an explanation of the test, the medical procedure, the nature of HIV/AIDS, and risk reduction strategies, although these requirements vary according to each state’s laws and practices. Thirty-one (31) states require informed consent among adult patients (see Table 2.2(B)). A few states allow consent to be obtained either orally or in writing (see Section 2.2, and Table 2.2(B)). Health care providers seeking to perform HIV testing as a part of routine care have to comply with these informed consent requirements, even if they potentially increase the time providers must devote to each patient. Additionally, informed consent requirements could deter some individuals from agreeing to be tested for HIV, due either to confidentiality concerns or to anxiety regarding the testing process itself.

3.1(e) Testing of Minors. As noted in Section 2.2, a few states regulate HIV testing for minors by requiring parental notification and/or consent prior to allowing testing to be performed. Eight (8) states (CA, CT, IL, MT, NY, NC, ND, OH) impose age limits and require that parents be notified before testing. Such requirements could impede health care providers' ability to test minors in a routine care setting. However, parental notification requirements could

also enhance a provider's ability to treat an HIV-infected minor. Parental involvement, education, and health care access may each contribute to successful interventions to effectively treat the minor, and limit potential for additional dissemination of HIV.

3.1(f) HIV Testing Protocols. Most states have created a protocol that must be followed for HIV testing. These protocols may include: (1) requirements for the use of specific tests; (2) confirmatory testing; or (3) requirements that testing be performed in state health department laboratories. At least fifteen (15) states regulate HIV testing in some manner, mandating that a protocol be followed before results can be provided to a patient. Such requirements could hinder the timeliness of HIV testing in routine care and necessitate follow-up visits once test results are confirmed. While confirmatory testing of preliminary HIV positive test results (and corresponding follow-up visits) are universal, and thus statutory requirements for these practices are not imposing, these requirements may interfere with rapid HIV testing.

Current advancements in rapid HIV testing could expedite the delivery of test results. Rapid HIV tests, which are used as HIV screening tests, are available for use at any clinical or non-clinical CLIA-approved "laboratory" (a facility performing examinations on humans). Any individual with a reactive (positive) test result must undergo follow-up testing through a more precise method, but individuals receiving a negative result do not need further testing.⁴⁹ A recent *New York Times* article discussed the emotional benefits that rapid HIV tests provide to the individuals being tested, as negative test results from a rapid test can be delivered within an hour as opposed to the seven (7) day wait required when standard HIV tests are used.⁵⁰ Yet, patients are still lost to follow-up even when rapid HIV tests are used; some individuals never return for their confirmatory test results. At present, only two (2) states (CA and OK) statutorily allow the

use of rapid tests, and at least fifteen (15) states (see Table 2.3(B)) statutorily require confirmatory testing.

3.2 *Implement new models for diagnosing HIV infections outside medical settings*

State statutes regulating the following areas could hinder or enhance the performance of HIV testing in non-routine settings.

3.2(a) Training and Certification Requirements. The potential impact of state legislation regarding training and certification requirements for individuals performing HIV tests depends on how the state actually defines testing. Some states regulate the withdrawal of blood for testing, while others regulate who can order an HIV test. At least forty (40) states regulate this latter aspect of HIV testing (see discussion in Section 2.1); some states only allow health care providers to test, but others have much broader requirements, potentially facilitating testing outside of traditional medical settings. Georgia permits a wide range of individuals to order HIV testing, including funeral directors, midwives, and psychologists, in addition to physicians, nurses and other health care providers.⁵¹ While NCSL provided a summary of state statutes regulating who can offer HIV testing and counseling, it did not provide specific information regarding the scope and focus of each individual state statute. (Additional legal research is needed to fully address these issues. For example, NCSL did not conduct specific research to examine who is statutorily authorized in each state to obtain blood samples for tests). Although HIV testing may be ordered by a wide range of professions, the testing process itself (withdrawal of blood, confirmatory testing) still necessitates the involvement of medical professionals.

3.2(b) Pre- and Post-test Counseling Requirements. In states that require pre- and post-test counseling, any state-mandated training would have to be completed by individuals outside of medical settings so that counseling could be provided appropriately. Twenty four (24) states

(see Table 2.2(A)) require pre-test counseling, and five states (AL, FL, ME, PA, TX) require post-test counseling in conjunction with HIV testing, and many states limit the ability to provide such counseling to health care providers. While these requirements do not present any new burdens for medical personnel who are already specifically trained, personnel in non-traditional testing sites could be required to undergo similar training or retain an HIV testing counselor that meets state requirements.

3.2(c) Testing in Educational and Employment Settings. As discussed in section 2.3, Kentucky, Maine, and Vermont specifically prohibit mandatory HIV testing as a requirement for employment or to enter the public education system. However, Texas has attempted to statutorily promote HIV testing and education by encouraging testing, though not mandatory, for all college students within the state through educational campaigns and increased access to testing services at student health clinics.⁵² Such legislation could serve as a model for advancing HIV testing and education in other arenas.

3.3 Further Decrease Perinatal HIV Transmission

According to CDC, the goal of this strategy is to make prenatal HIV screening a routine part of prenatal care and encourage rapid HIV testing of the mother at labor and delivery if she does not have a documented prenatal test. The infant receives a rapid HIV test before discharge only if the mother cannot be tested.

While NCSL did not extensively address perinatal HIV testing issues through its research, the *Center's* limited research on these laws provides some initial insight. Some states have enacted legislation related to prenatal and newborn HIV screening. A few states (TX, AR,⁵³ TN,⁵⁴ MI⁵⁵) require that HIV testing be included as a part of routine prenatal care unless the mother opts-out, while other states (CA, WA, IA, LA, IN, KY, FL, VA, NJ, MD, RI) require

health care providers to offer HIV testing and education to pregnant women. CDC supports the provision of written information about perinatal HIV transmission and prevention to pregnant women. Additional research is needed to fully determine which states require verbal pre-test counseling for perinatal HIV tests and which require written consent specifically for a perinatal HIV test.

New York⁵⁶ and Connecticut⁵⁷ have enacted statutes mandating HIV testing of newborns, and do not require parental consent prior to the testing of newborns when the mother has declined testing. These states allow refusal of testing based on a parent's religious beliefs.⁵⁸ In all, at least seventeen (17) states (see Table 2.3(H)) have regulated prenatal or newborn HIV screening in some manner. In no state is prenatal HIV testing compulsory.

The “opt-out” approach mentioned in the AHP Initiative could limit the number of women deterred by the potential of HIV testing by allowing for an easy opportunity to refuse an HIV test. However, the “opt-out” approach may potentially contradict state statutes requiring pre-test counseling and informed consent. Health care providers must be conscious of providing all statutorily required information prior to administering an HIV test to comply with pre-test counseling requirements not associated with standard prenatal tests. CDC has found that in at least one state, Alabama, the state Medicaid policy required written informed consent for a prenatal HIV test. This is contrary to CDC’s opt-out approach in which specific, written informed consent for prenatal HIV test is not required. Additional legal research is needed to determine if policies in other states may also impact the practice of perinatal HIV testing, even if state statutory laws do not.

4.0 CONCLUSION

CDC's AHP Initiative was developed with the goal of identifying HIV-infected individuals unaware of their status and providing these individuals with prevention services, counseling, education and treatment. CDC aims to utilize the efforts and resources of federal, state, and local public health officials, health care providers and their partners to reduce HIV infections nationwide. Given the need for collaboration on state and local levels, current state statutes have the potential to affect the performance of multiple activities pursuant to the AHP strategies. State legislative provisions regulate the personnel who may administer HIV tests, set pre-test requirements, determine certain protocols and other requirement concerning testing itself, and feature some post-test requirements.

States' statutes identified by NCSL can enhance or hinder the ability to accomplish AHP's strategies. These statutes are most likely to affect the first two strategies of the AHP initiative, regarding making HIV testing a routine part of medical care and implementing new models for diagnosing HIV infections outside medical settings. State laws also provide a sound basis for some interventions and activities, as well as support AHP's third strategy (prevent infections by working with people diagnosed with HIV and their partners) and fourth strategy (further decrease perinatal HIV transmission). While this analysis pursuant to a comprehensive statutory review provides guidance for public health officials seeking to fulfill the strategies of the AHP initiative, a complete review of the legal environment (including state policies and practices) will enhance the understanding and assessment of the role of law in these areas.

REFERENCES

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- ¹ AHP Initiative Quick Facts. Available at: <http://www.cdc.gov/hiv/partners/QuickFacts.htm>.
- ² AHP Program Outline. Available at: http://www.cdc.gov/hiv/partners/ahp_program.htm.
- ³ Please note that the Center's assessment of state HIV laws has been specifically limited to the research findings produced by NCSL at the request of NCHSTP. Thus, this analysis does not address administrative regulations, judicial case law, city ordinances, federal legislation, or other state or federal policies that may also impact the performance of the AHP Initiative objectives.
- ⁴ In a second stage of this assessment (*subject to funding*), the *Center* proposes conducting additional legal research among several states and at the federal level to further analyze the legal environment in which the strategies of the AHP Initiative shall be accomplished. The culmination of this second stage is the production of a comprehensive, additional report that features state-based case studies and critical analysis, and is informed by the contributions of an expert advisory panel (comprised of public health practitioners at each level of government, additional scholars, legal practitioners, and others).
- ⁵ Cal Health & Saf Code 121065 (2003).
- ⁶ OCGA 31-22-9.1.
- ⁷ KRS 214.610 (2002).
- ⁸ ORC 3701.24.1.
- ⁹ Cal Health & Saf Code 120871 (2003).
- ¹⁰ Conn. Gen. Stat. 19a-584 (2003).
- ¹¹ 16 Del. C. 1202 (2003).
- ¹² Md. Code Ann. 18-336 (2002).
- ¹³ Cal Health & Saf Code 120990 (2003).
- ¹⁴ Fla. Stat. 947.1405 (2002).
- ¹⁵ Fla. Stat. 960.003 (2002).
- ¹⁶ Fla. Stat. 960.003 (2002).
- ¹⁷ 10 Del. C. 1077 (2003).
- ¹⁸ ORC Ann. 3701.242 (Anderson 2003).
- ¹⁹ N.C. Gen. Stat. 130A-148.
- ²⁰ HRS 325-17 (2003).
- ²¹ C.R.S. 10-3-1104.5 (2002).
- ²² Frequently Asked Questions about the OraQuick Rapid HIV-1 Antibody Test. Available at: <http://www.cdc.gov/hiv/PUBS/faq/oraqckfaq.htm>.

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- ²³ NY CLS Pub Health 570-581.
- ²⁴ 410 ILCS 305/5.5 (2004)
- ²⁵ Rapid Testing for HIV. Available at: <http://www.health.state.ny.us/nysdoh/hiv aids/rapid/protocol.htm>.
- ²⁶ La. R.S. 40:1300.13 (2003).
- ²⁷ 5 M.R.S. 19203-B (2003).
- ²⁸ Conn. Gen. Stat. 19a-582 (2003).
- ²⁹ Code of Ala. 22-11A-17.
- ³⁰ Cal Pen Code 1201.1 (2003).
- ³¹ Iowa Code 915.42 (2003).
- ³² Minn. Stat. 611A.19 (2002).
- ³³ KRS 207.135 (2002).
- ³⁴ KRS 207.135 (2002); 5 M.R.S. 19204-B (2003).
- ³⁵ 18 V.S.A. 1127.
- ³⁶ Texas Educ. Code 51.919 (2003).
- ³⁷ 5 M.R.S. 19204-A (2003).
- ³⁸ Code of Ala. 22-11A-53 (2003).
- ³⁹ O.C.G.A. 16-5-60 (2002).
- ⁴⁰ NY CLS Pub Health 2307 (2004).
- ⁴¹ CDC has suggested that state HIV statutes do not impact the third AHP Initiative objective, “Prevent new infections by working with people diagnosed with HIV and their partners,” after reviewing initial analysis of potential impacts in a prior draft of this document.
- ⁴² Cal Health & Saf Code 120871.
- ⁴³ Conn. Gen. Stat. 19a-594.
- ⁴⁴ Fla. Stat. 456.033.
- ⁴⁵ KRS 214.610.
- ⁴⁶ La. R.S. 40:2018.2.
- ⁴⁷ ORC Ann. 3701.241.
- ⁴⁸ Tex. Health & Safety Code §§ 85.087, 464.012.
- ⁴⁹ Frequently Asked Questions about the OraQuick Rapid HIV-1 Antibody Test. Available at:

<http://www.cdc.gov/hiv/PUBS/faq/oraqckfaq.htm>.

⁵⁰ Tuller D. The New HIV Test Offers Quicker Results, but the Same Agony. *New York Times*, June 1 2004.

⁵¹ OCGA 31-22-9.1.

⁵² Texas Educ. Code 51.919 (2003).

⁵³ A.C.A. 20-16-507 (2003).

⁵⁴ Tenn. Code Ann. 68-5-703 (2003).

⁵⁵ CDC reports that Michigan law requires that pregnant women be offered HIV testing unless the woman does not consent. Less clear is the extent to which the practice in Michigan is to streamline pre-test counseling and consent requirements, and to incorporate HIV testing into the standard battery of prenatal tests. The Michigan state health department suggested in 2003 that Michigan did not qualify as an “opt-out” state.

⁵⁶ NY CLS Pub Health 2500-f (2004).

⁵⁷ Conn. Gen. Stat. 19a-55 (2003).

⁵⁸ HIV Testing Among Pregnant Women --- United States and Canada --- 1998-2001. *MMWR Weekly*, November 2002. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5145a1.htm>.