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Testimony of the New York Civil Liberties Union
Before the Joint Legislative Budget Hearing on Health

January 23, 2024

The New York Civil Liberties Union (NYCLU) is grateful for the opportunity to submit the following testimony for the Joint Legislative Budget Hearing on Health. The NYCLU, the New York state affiliate of the American Civil Liberties Union, is a not-for-profit, nonpartisan organization with eight offices across the state and over 180,000 members and supporters. The NYCLU defends and promotes the fundamental principles and values embodied in the Bill of Rights, the U.S. Constitution, and the New York Constitution through an integrated program of litigation, legislative advocacy, public education, and community organizing. As the legal arm of New York's reproductive rights movement, the NYCLU strives to ensure that New York remains a beacon for equality and bodily autonomy and the full range of reproductive rights, from access to abortion care to birth justice. The NYCLU has also been at the forefront of combatting discrimination against and criminalization of people living with HIV and continues to work to expand access to prophylaxis, testing, and treatment.

I. Access to Reproductive Health Care

In June 2022, the Supreme Court overturned *Roe v. Wade*, ending the federal constitutional right to abortion. In the wake of the *Dobbs* decision, nearly half of the states are poised to completely ban abortion[1] – and many already have.[2] Nationwide, at least 66 clinics have stopped providing abortion care since the *Dobbs* decision, and 26 have shut down completely.[3] Meanwhile, a federal lawsuit, now pending before the U.S. Supreme Court, threatens the availability of mifepristone, the first of two drugs used in medication abortion

[1] *State Legislation Tracker: Major Developments in Sexual & Reproductive Health*, GUTTMACHER INSTITUTE, https://www.guttmacher.org/state-legislation-tracker (last visited Feb. 27, 2023).
[2] *After Roe Fell: Abortion Laws by State*, CENTER FOR REPRODUCTIVE RIGHTS, https://reproductiverights.org/maps/abortion-laws-by-state/ (last visited Feb. 27, 2023).
[3] Marielle Kirstein, Joerg Dreweke, Rachel K. Jones, & Jesse Philbin, *100 Days Post-Roe: At Least 66 Clinics Across 15 States Have Stopped Offering Abortion Care*, GUTTMACHER INSTITUTE, Oct. 6, 2022, https://www.guttmacher.org/2022/10/100-days-post-roe-least-66-clinics-across-15-us-states-have-stopped-offering-abortion-care.

in the United States, in all 50 states, including New York.[4] This case could provoke yet another seismic shift in access to abortion care in this country.

The impacts of being denied abortion care are profound[5] and most deeply impact those who are already multiply burdened by systemic racism and economic injustice.[6]

Against this backdrop, New York is called upon to be a beacon. To meet this moment, New York must codify and fund an access agenda.

A. Fund Abortion Access

In 2019, the Reproductive Health Act created statutory protections for abortion care in New York. But the right to abortion is only theoretical for many people. Many New Yorkers lack the money necessary to pay for abortion care and to cover the costs of travel, lodging, childcare, and other expenses required to obtain that care.

And, because Medicaid reimbursement rates in New York have been stagnant for a decade and are significantly below the cost of providing care, providers actually lose money every time they provide abortion care.[7] Other access states, like California, Oregon, and Illinois,[8] have increased their reimbursement rates, and New York must do the same. We are grateful that in last year's budget, New York increased Medicaid reimbursement rates for procedural abortion care and sexual family planning services. This year, it must finish the job. The legislature must insist on increases to reimbursement rates for medication abortion care as well. Medication abortion accounts for more than half of all abortions in New York, as well as nationwide.[9] As New York providers strive to meet the current moment, it is simply untenable to ask them to operate continually at a loss.

In addition, the legislature should include the Reproductive Freedom and Equity Fund (S.348-C/A.361-B) in its one house budget proposals and ensure that the measure remains in the enacted budget. The Reproductive Freedom and Equity Fund will establish a comprehensive, sustainable state program that will invest in providers, abortion funds, and logistical support funds – the ecosystem that makes access to care a reality in New York. In

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[4] *See generally* Dahlia Lithwick & Mark Joseph Stern, *Dobbs Was Always Just the Beginning*, SLATE, Feb. 6, 2023, https://slate.com/news-and-politics/2023/02/abortion-pill-outlawed-single-judge-real-possibility.html.
[5] *The Turnaway Study*, ANSIRH, https://www.ansirh.org/research/ongoing/turnaway-study (last visited Feb. 27, 2023).
[6] Liza Fuentes, *Inequity in US Abortion Rights and Access: The End of Roe is Deepening Existing Divides*, GUTTMACHER INSTITUTE, Jan. 17, 2023, https://www.guttmacher.org/2023/01/inequity-us-abortion-rights-and-access-end-roe-deepening-existing-divides.
[7] *SEE* TESTIMONY OF PLANNED PARENTHOOD EMPIRE STATE ACTS, TESTIMONY BEFORE THE JOINT LEGISLATIVE BUDGET HEARING ON HEALTH AND MEDICAID (2023).
[8] *Id*.
[9] *Id*.

order to seed the Reproductive Freedom and Equity Fund, we urge the legislature to maintain the Governor's proposed $25 million in grant funding for abortion providers and add an additional $1 million to support abortion funds and logistical support funds. The need is great. For example, the New York Abortion Access Fund (NYAAF) pledged more than $1.8 million in direct abortion funding to 1,869 people in 2023 – a 46% increase from 2022 and a 228% increase from 2021.[10] The Brigid Alliance, a New York-based logistical support fund, reports that their revenue decreased by 152% between May 2022 and May 2023.[11] The $1 million for abortion and logistical support funds would match New York City's investment[12] and is a fraction of what California and Oregon have committed to abortion and logistical support funds.[13] Importantly, the bulk of this funding will be spent in New York to support New Yorkers. 66% of NYAAF's callers are New Yorkers, and 96% receive care in New York.[14]

Finally, the legislature should continue the $1 million legislative add for the family planning grant, because a holistic investment in family planning services and family planning is essential to ensure that New York's sexual and reproductive health care providers can continue to provide comprehensive care to meet this moment.

B. Clarify that Young People Can Consent to Abortion Care

Decisionally-capable[15] young people in New York have long been able to consent to abortion care without involving a parent or guardian.[16] Permitting young people to consent to their own care advances important health goals, because the data demonstrate that in many cases, young people will not seek health care if they are required to involve a parent or their

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[10] Email from Chelsea Williams-Diggs, Interim Executive Director, New York Abortion Access Fund, to Niharika Rao, Political and Legislative Affairs Associate, National Institute for Reproductive Health (December 13, 2023).
[11] Alison Durkee & Darreonna Davis, *Roe v. Wade Overturned One Year On: Here's Where the Money's Going*, FORBES, June 24, 2023, https://www.forbes.com/sites/alisondurkee/2023/06/23/roe-v-wade-overturned-one-year-on-heres-where-the-moneys-flowing-abortion/?sh=34e21e507028.
[12] Press Release, New York City Council, Speaker Adrienne Adams, First-Ever Women Majority New York City Council Announce Largest Commitment of Municipal Funds by Any City in U.S. to Support Increased Access to Abortion Care (Sept. 13, 2022) (https://council.nyc.gov/press/2022/09/13/2254/#:~:text=City%20Hall%2C%20NY%20%E2%80%93%20Council%20Speaker,city%20in%20the%20United%20States).
[13] S.184, 2021-2022 Reg. Sess. (C.A. 2022) (commits $20 million to the Abortion Practical Support Fund); H.5202 2022 Reg. Sess. (OR 2022) (commits $15 million to the Reproductive Health Equity Fund).
[14] Email from Chelsea Williams-Diggs, Interim Executive Director, New York Abortion Access Fund, to Niharika Rao, Political and Legislative Affairs Associate, National Institute for Reproductive Health (December 13, 2023).
[15] Decisionally-capable describes young people who are mature enough to understand the need for, the nature of, and the reasonably foreseeable risks and benefits involved in a contemplated health care, as well as any alternatives to that care. N.Y. Pub. Health Law § 2805-d(1) (McKinney).
[16] *See* Letter from Mary T. Bassett, Commissioner, New York State Department of Health, to Provider (May 6,2022).

confidentiality is compromised.[17] However, with the *Dobbs* decision, the Supreme Court made clear that it is angling at many of the rights that New Yorkers have long taken for granted.[18] For this reason, the NYCLU welcomes the spirit of Governor Hochul's proposal in HMH Part N to clarify in Public Health Law 2504 that young people can consent to abortion care.

We strongly encourage the legislature to make all changes related to minors' ability to consent to reproductive health care in section 2504 of the Public Health Law. Section 2504 governs who may consent to health care and is the established place to clarify that decisionally-capable young people are among those who may consent to abortion care.

C. Clarify that Young People Can Consent to Contraception

Similarly – and for the same reasons – decisionally-capable young people in New York have long been able to consent to contraception without involving a parent or guardian.[19] However, just as it is imperative to clarify in statute that decisionally-capable young people can consent to abortion care, it is important to clarify in statute that decisionally-capable young people can consent to contraception, and the NYCLU applauds Governor Hochul for prioritizing this in HMH Part N.

As with the ability to consent to other reproductive health care, it is important to place this provision in Public Health Law 2504, which defines who may consent to care. Furthermore, the Governor introduces a new standard – whether a patient can "medically tolerate such treatment"[20] – that is otherwise not present in either law nor medicine to determine when a young person can receive contraception without involving a parent or guardian. The legislature should instead clarify in Public Health Law 2504 that young people can consent

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[17] Jonathan Klein et al., "Access to medical care for adolescents: Results from the 1997 Commonwealth Fund Survey of the Health of Adolescent Girls," 25 J. OF ADOLESCENT HEALTH 120 (1999).
[18] *See Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215, 362 – 63 (2022) (Breyer, J., Sotomayor, J., and Kagan, J., dissenting) ("And no one should be confident that this majority is done with its work. The right *Roe* and *Casey* recognized does not stand alone. To the contrary, the Court has linked it for decades to other settled freedoms involving bodily integrity, familial relationships, and procreation. Most obviously, the right to terminate a pregnancy arose straight out of the right to purchase and use contraception. See *Griswold v. Connecticut*; *Eisenstadt v. Baird*. In turn, those rights led, more recently, to rights of same-sex intimacy and marriage. See *Lawrence v. Texas*; *Obergefell v. Hodges*. They are all part of the same constitutional fabric, protecting autonomous decisionmaking over the most personal of life decisions. The majority (or to be more accurate, most of it) is eager to tell us today that nothing it does "cast[s] doubt on precedents that do not concern abortion." . . . (THOMAS, J., concurring) (advocating the overruling of *Griswold*, *Lawrence*, and *Obergefell*). But how could that be?" (internal citations omitted)).
[19] *Carey v. Population Services Int'l*, 431 U.S. 678 (1977).
[20] A.8807/S.8307 Part N, § 4, 2023-2024 Reg. Sess. (NY 2024).

to contraception based on the informed consent standard[21] that has long been the hallmark of access to health care in New York state.

The NYCLU has been providing legal counsel to health care providers regarding young people's ability to consent to health care for decades, and we look forward to working with the legislature and the executive to ensure that the final budget language advances access to health care.

D. Electronic Reporting of Induced Termination of Pregnancy

The Governor's 2024 State of the State briefing book included a proposal to "modernize technology for the electronic reporting of induced termination of pregnancy instances in order to . . . provide safeguards for sensitive abortion-related information."[22] Unfortunately, the Governor's Article VII legislation does not appear to include language operationalizing this intention.

New York statutory law currently requires "fetal death certificates" to be filed within 72 hours of a miscarriage, stillbirth, or abortion. In practice, this requires providers to obtain hard copy forms from the local registrar – often a county clerk – and submit the completed forms, again, in hard copy, to the Department of health and the local registrar.[23] This requirement is administratively burdensome for providers, who have seen a 25% increase in the need for abortion since 2020,[24] and diverts staff time that could be used to support the provision of care. Moreover, the requirement poses privacy risks for abortion patients, including those who travel to New York from states that have banned abortion.

We understand that the Department of Health is in the process of acquiring a new electronic vital records system. The NYCLU recognizes that statutory changes will be necessary to enable providers to report electronically and strongly supports leveraging the new system to modernize pregnancy loss reporting to protect patient privacy and reduce burdens on providers. Specifically, the State should take this opportunity to extend the deadline for reporting pregnancy loss, move to aggregate reporting that protects patient confidentiality – Massachusetts provides a good model – and modernize the language for pregnancy loss reporting to use gender-inclusive language and eliminate medically inappropriate terminology, including by changing the name of a "fetal death certificate" to a "pregnancy loss certificate."

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[21] N.Y. Pub. Health Law § 2805-d(1) (McKinney) ("Lack of informed consent means the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical, dental or podiatric practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation.").
[22] GOVERNOR KATHY HOCHUL, STATE OF THE STATE 2024: OUR NEW YORK, OUR FUTURE 136 (2024).
[23] *See* N.Y. Pub. Health Law. §§ 4160, 4163 (McKinney).
[24] *See Monthly Abortion Provision Study*, GUTTMACHER INSTITUTE, https://www.guttmacher.org/monthly-abortion-provision-study (last visited Jan. 22, 2024).

II. Improving Maternal and Infant Health Outcomes

As the legislature is certainly aware, New York faces a maternal mortality crisis that is five times more severe for Black women than for white women and nine times more severe for Black women in New York City. Addressing these disparities and improving maternal and infant health outcomes across the board must be an urgent imperative for the legislature. We were heartened to see this issue highlighted as an area of focus in Governor Hochul's State of the State and encourage the legislature to prioritize it in one house budgets and negotiations. In doing so, we urge lawmakers to reckon with the underlying drivers of adverse maternal health outcomes, including the centuries-long history of racism and misogyny on which the maternal health care delivery system is built. Measures aimed at reducing racial disparities in maternal and infant health must be intentionally divorced from institutions of surveillance and punishment, such as the family regulation system, and must affirm pregnant people's dignity and equality under the law.

A. Informed Consent for Drug Testing Pregnant People and Infants

The NYCLU is pleased that Governor Hochul included a proposal in this year's State of the State to require informed consent before drug testing a pregnant person or infant – a position we have supported for several years as embodied in A.109-B/S.320-B.[25] Although the executive budget legislation did not include language to effectuate this proposal, we are hopeful that it will be added through the 30-day amendment process, and we urge the legislature to include informed consent in their one house budget proposals.

Drug testing or screening pregnant people and infants without notice, meaningful consent, or any medical reason has dire consequences for maternal and infant health – especially for Black and Brown pregnant people, who are disproportionately targeted for testing and who already face significantly higher rates of maternal mortality and morbidity.[26] Positive drug tests and screens often trigger reports to Child Protective Services, which can lead to new parents being questioned and investigated while still in their hospital beds and can cause infants to be removed from their parent's care mere hours after birth.[27] The stress of these

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[25] *See*, *2023-2024 Memorandum of Support: A.109(Rosenthal)/S.320(Salazar)*, New York Civil Liberties Union, https://www.nyclu.org/en/legislation/legislative-memo-prohibiting-drug-testing-pregnant-people.

[26] Nicola C. Perlman, David E. Cantonwine, and Nicole A. Smith, *Racial Differences in Indications for Obstetrical Toxicology Testing and Relationship of Indications to Test Results*, American Journal of Obstetrics & Gynecology MFM (Jan. 2022), https://drive.google.com/file/d/1ZVi1M6i1CcinTkq0NWruDAqCo8FwJafz/view?usp=sharing (concluding that, "compared with their White counterparts, Black and Hispanic pregnant and delivering patients may be more frequently toxicology tested for indications less clearly associated with illicit substance use.").

[27] *See*, The Bronx Defenders, Brooklyn Defender Services, Movement for Family Power, Ancient Song Doula Services, Pregnancy Justice (formerly National Advocates for Pregnant Women, and New York

investigations and removals is both devastating for parents and highly detrimental to infant development.[28] Moreover, the practice of non-consensual drug testing has been shown to damage the doctor-patient relationship and deter pregnant people from seeking vital prenatal and perinatal care, which can in some cases lead to adverse pregnancy outcomes.[29] Indeed, there is consistent overlap between the New York City zip codes with high rates of child removals and high rates of Black maternal mortality. Accordingly, major medical and public health associations strongly oppose this practice.[30]

As New York urgently strives to address the state's maternal mortality crisis, we encourage the legislature to include in the budget a requirement that health care providers obtain written and verbal informed consent before performing a drug or alcohol test or screen on a pregnant patient or their infant. It is essential that this consent requirement extend to both pregnant people and infants, as well as to both biologic tests and verbal screens. These components are necessary to support trust and openness between patients and their

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Civil Liberties Union, *Joint Testimony before the New York State Senate Committee on Women's Issues Regarding Maternal and Child Health in Upstate New York*, at 6 (Nov. 2020), https://www.nyclu.org/sites/default/files/20201204-jointtestimony-maternalandchildhealth.pdf.

[28] *See*, American Bar Association, *Trauma Caused by Separation of Children from Parents* (May 2019), https://www.americanbar.org/content/dam/aba/publications/litigation_committees/childrights/child-separation-memo/parent-child-separation-trauma-memo.pdf.

[29] *See*, DeAnna Y. Smith and Alexus Roane, *Child Removal Fears and Black Mothers' Medical Decision-Making*, 22.1 Contexts 18 (2023), https://doi.org/10.1177/15365042221142834 (describing how "Black mothers are highly aware of the collaboration between the health care system and punitive institutions like CPS" and how "fear of child removal not only shapes *how* Black mothers receive maternity and pediatric care for themselves and their children but also *where* they receive care."); National Perinatal Association, *Position Statement, Perinatal Substance Use* (2017) (warning that "threats of discrimination, incarceration, loss of parental rights, and loss of personal autonomy are powerful deterrents to seeking appropriate prenatal care"); Meenakshi S. Subbaraman et. al., *Associations Between State-Level Policies Regarding Alcohol Use Among Pregnant Women, Adverse Birth Outcomes, and Prenatal Care Utilization: Results from 1972 to 2013 Vital Statistics*, Alcohol Clinical and Experimental Research (June 2018), https://doi.org/10.1111/acer.13804 (concluding that "most policies targeting alcohol use during pregnancy do not have their intended effects and are related to worse birth outcomes and less [prenatal care utilization].").

[30] *See e.g.*, American College of Obstetricians and Gynecologists, *ACOG Committee Opinion: Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice*, No. 633, June 2015 (rejecting practices that screen pregnant people for substance use via drug testing and recommending that drug testing of pregnant people only be performed with the patient's verbal and written consent and after they have been "informed of the potential ramifications of a positive test result, including any mandatory reporting requirements."); American Society of Addiction Medicine, *Appropriate Use of Drug Testing in Clinical Addiction Medicine*, April 2017, https://bit.ly/3L50AIA (recommending that, "with the exception of emergency situations, pregnant women should provide explicit written consent for drug testing including during labor and delivery. This informed consent should include an understanding of the possible consequences of test results."); Center for Substance Abuse Treatment, *A Guide to Substance Abuse Services for Primary Care Clinicians,* Treatment Improvement Protocol Series, No. 24, Appendix B—Legal and Ethical Issues (1997), https://www.ncbi.nlm.nih.gov/books/NBK64825/ (noting that "a patient confronted with the results of a test [s]he did not know about and did not consent to may feel betrayed by the clinician…[and] may refuse to participate in any further discussion about [her] substance use problem.").

providers at each stage of their prenatal, perinatal, and pediatric care journey. Additionally, in soliciting a patient's consent, health care providers must be required to provide the medical reason for conducting the test or screen, as well as information about the potential consequences that may stem from a positive answer or result. These measures are key to ensuring that when consent is given, it is done so from an informed position.

B. Improving Access to Doula Care

Another proven way to improve maternal and infant health outcomes is to increase access to birth workers, such as doulas and midwives. Studies have found doula care to be associated with lower rates of Cesarean sections, preterm birth, low birthweight, and postpartum depression, and it may help to reduce the disproportionate rates of maternal morbidity and mortality among Black women.[31] Accordingly, the NYCLU supports measures that would expand access to doula care, including by waiving the physician referral requirement as currently proposed in HMH Part N.

C. Additional Measures to Improve Maternal and Infant Health Outcomes

Governor Hochul initially included in her State of the State several other proposals to improve maternal and infant health that are not included in the executive budget legislation. We are eager to work with the legislature to explore additional measures that would expand access to the resources and supports needed to support healthy pregnancies, reduce obstetric violence,[32] and affirm pregnant people's equality and autonomy under the law.

III. Interstate Licensing Compacts

HMH Part R would make New York State a party to the Interstate Medical Licensure and Interstate Nurse Licensure Compacts. While participation in these compacts carries benefits – namely, it may facilitate more providers becoming licensed to practice in New York State – it also presents significant risks to New York's ability to protect reproductive and gender-

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[31] New York City Department of Health and Mental Hygiene, *The State of Doula Care in NYC 2020*, at 5, https://www.nyc.gov/assets/doh/downloads/pdf/csi/doula-report-2020.pdf; March of Dimes, *Position Statement: Doulas and Birth Outcomes* (Jan. 2019), https://www.marchofdimes.org/sites/default/files/2023-04/Doulas-and-birth-outcomes-position-statement-final-January-30.pdf

[32] The term "obstetric violence" refers to mistreatment during childbirth that may be abusive, coercive, and/or disrespectful, "including, but not limited to, violations of the rights to informed consent and bodily autonomy, which lead to both physical and emotional harms." Elizabeth Kukura, *Obstetric Violence*, 106 GEORGETOWN L. J. 721 (2018), https://www.law.georgetown.edu/georgetown-law-journal/wp-content/uploads/sites/26/2018/06/Obstetric-Violence.pdf. It encompasses things like forced surgery and unconsented medical procedures, coercion through judicial intervention, the threat of involvement with the family regulation system, withholding of pain medication, disrespectful comments, and violations of privacy, among other conduct. *Id.* Obstetric violence may be perpetrated by physicians or nurses, as well as other professional staff present during labor and delivery. *Id.*

affirming care providers from investigation, professional discipline, and potentially prosecution by other states. The compact language requires member states to participate in information exchanges, reciprocal disciplinary schemes, and mutual subpoena enforcement, which could complicate the application of New York's recently enacted shield laws. Our shield laws are designed to ensure that New York State is not complicit in any attempts to punish those who provide, receive, or support access to reproductive and gender-affirming care by New York providers, including by preventing the state from cooperating with investigations, domesticating subpoenas, or pursuing professional discipline against providers related to their provision of reproductive or gender-affirming care. However, by participating in an interstate compact, New York would be bound to comply with compact provisions that may come into conflict with these shield law prohibitions, thereby undermining the state's ability to protect providers.

The NYCLU recognizes that New York State faces a shortage of sexual and reproductive health care providers, without whom we cannot maintain a well-functioning, equitable health care system. We would encourage the legislature to consider other solutions, such as S.4148-A, which would allow reproductive health care providers who are licensed in another state to practice in New York under a provisional license while their application for New York State licensure is pending, and to seriously weigh the risks inherent in joining an interstate licensure compact.

IV. Ending the HIV Epidemic

While New York has made considerable progress in reducing the prevalence of HIV over the last decade,[33] the COVID-19 pandemic exacerbated hurdles to HIV prevention, testing, and treatment. Moreover, New York continues to see stark disparities in HIV's impact with Black, Indigenous, and other New Yorkers of color, as well as transgender New Yorkers and young men who have sex with men, bearing the brunt of the epidemic.[34] The NYCLU embraces the goal of Ending the Epidemic. Unfortunately, only part of HMH Part T advances this goal while the other part of HMH Part T undermines it.

A. Decriminalize Sexually Transmitted Infections (STIs)

The NYCLU strongly supports the Governor's proposal in Section 9 of HMH Part T to repeal New York's STI criminalization law, Public Health Law § 2307. At present, New York criminalizes people for having sex if they have a sexually transmitted infection (STI). This crime carries no intent requirement and no transmission requirement, and open disclosure to one's partners is no defense. Defense attorneys report that New York prosecutors have weaponized this statute to prosecute people living with HIV who have sex.

[33] New York State Budget and Policy Priorities NYS Fiscal Year 2025, Ending the Epidemic 2 (Nov. 2023).
[34] *Id*.

This is bad public policy. Laws that criminalize people living with HIV/AIDS and STIs discourage people from learning and disclosing their status, ignore science, harm patient relationships with counselors and doctors, and perpetuate stigma. Recognizing these realities, 12 states have amended or repealed their laws criminalizing HIV/AIDS since 2014. New York must join these states, and the Section 9 of the Governor's HMH Part T is a good start.

The legislature should go further by including the entirety of S.4603 (Hoylman-Sigal)/A.3347 (Gonzalez-Rojas), the REPEAL STI Discrimination Act, in its one house budgets. In addition to repealing Public Health Law § 2307, the REPEAL STI Decriminalization Act automatically expunges past convictions under the criminal law that the bill would repeal. And, the bill takes steps to ensure that law enforcement cannot continue to weaponize other criminal statutes to prosecute those living with HIV or STIs solely based on their health status after New York's explicit STI criminalization law is removed from the books.

STI criminalization undermines public health and disproportionately impacts communities of color, particularly LGBTQ+ communities of color. The New York legislature must take this opportunity to wholistically repeal it by including S.4603/A.3347 in its one house budgets and fighting for them at the negotiating table.

B. Patient Autonomy in HIV Testing

Section 4 of HMH Part T proposes to eliminate notice and consent for an individual who is about to be tested for HIV. It also proposes to remove the requirement that patients be offered the opportunity to anonymously test for HIV, if that is the option that is safest for them. Instead, providers would be permitted to simply notify patients of HIV testing with posted placards in their offices and waiting rooms.

Notices on the walls of busy clinics, waiting rooms, and emergency departments do not constitute effective notice to a person presenting for care that they must assert an objection at some point to avoid being tested for HIV. This approach ignores the fact that many of those seeking care do not have functional vision, cannot read, do not speak English or any of the other languages a notice might be posted in, or have mental or cognitive impairments – and that they often present in the kind of physical distress from acute pain or illness that precludes simultaneously understanding that at some unidentified point they must object or they will be tested for HIV.

The proposal also ignores the reality that for those who are undocumented, testing for HIV while being treated for an acute health care need may place their ability to stay in or return

to this country in peril.[35] It ignores the all too frequent scenario of people in mental health crisis, as well as people of color, who are brought into an ER for injuries sustained after "resisting arrest"; with this proposal, arresting officers may have access to HIV test results, which can turn a mishandled arrest into a felony charge for the arrested individual.

Strikingly, this proposal is being advanced with no data to support it. While there is unquestionably an ongoing problem of late HIV diagnoses and dual diagnoses in New York State, proponents of eliminating notice and consent for HIV testing offer no data to suggest that eliminating notice will solve that problem. In fact, it is unclear whether people who are dually diagnosed have previously had contact with medical providers, have been offered and declined testing in the past, or have never been offered HIV testing at all in violation of existing New York law.[36]

Where providers are already violating New York State law by declining to offer HIV testing, it is hard to imagine that they will engage in conversations with patients who test positive about the meanings of those results, the benefits of treatment, and how to connect with appropriate providers and treatment options.

Moreover, testing without notice, consent, or transparency threatens to erode trust between patients and medical providers, especially given the HIV stigma and discrimination that many patients will have experienced both in the medical and the legal establishments.[37] In fact, rather than increasing access to HIV treatment, perversely testing people without their knowledge or consent risks alienating them from pursuing further care. Patients may think twice about again seeking medical treatment, including HIV treatment, for fear that they will be subjected to further testing or interventions without their notice and consent.

The concern is particularly acute among Black, Indigenous, and other communities of color, who have long suffered from medical mistreatment. Many, particularly in the Black community, remember the Tuskegee syphilis study – when, in the 1930s, the U.S. government studied the trajectory of untreated syphilis in hundreds of Black men, both concealing the nature of their research and withholding effective treatment after one had been identified.[38] Indigenous Americans, too, have survived "significant unethical research

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[35] *See* "HIV Criminalization in California: What We Know," The Williams Institute, *available at* https://williamsinstitute.law.ucla.edu/wp-content/uploads/HIV-Criminalization-What-We-Know-2017.pdf ("Based on the data available, it did appear that there were some individuals who had deportation proceedings brought immediately after an HIV-specific criminal incident.").
[36] N.Y. Pub. Health § 2881-a (McKinney) (requiring that medical providers offer testing to all individuals over thirteen years old with limited exceptions).
[37] *See e.g.*, McAllister, Carolyn, Susan Reif, and Elena Wilson, *Perceptions and Impact of HIV Stigma Among High Risk Populations in the US Deep South*, J. OF HIV AND AIDS (April 6, 2018), *available at* https://www.hivlawandpolicy.org/sites/default/files/Perceptions%20and%20Impact%20of%20HIV%20Stigma%20 among%20High%20Risk%20Populations%20in%20the%20US%20Deep%20South.pdf.
[38] Peter Jamison, *Anti-vaccination leaders fuel [B]lack mistrust of medical establishment as covid-19 kills people of color*, WASH. PO., July 17, 2020, https://www.washingtonpost.com/dc-md-

and medical care" since colonization.[39] And, Latinx New Yorkers remember that between the 1930s and the 1970s, approximately one-third of Puerto Rican women and girls were forcibly sterilized.[40] This history feels strikingly present as immigrants detained in ICE facilities in Georgia as recently as 2020 reported forced hysterectomies.[41]

The legislature has recognized time and again during the COVID-19 pandemic that people will not seek health care if they worry that it will lead to criminalization or negative immigration consequences and that forcefully imposing testing or treatment on individuals can perversely drive them away from health care settings. It is for those reasons that this legislature enacted contact tracing confidentiality in 2020[42] and vaccine confidentiality in 2022.[43] The same rationale animates the laudable effort, also reflected in the Governor's HMH Part T, to repeal New York's STI and HIV criminalization law, Public Health Law § 2307.[44] The legislature should adhere to these values and public health goals by rejecting the Governor's changes to Public Health Law §§ 2781(1) and (4) (in Section 4 of her HMH Part T proposal) in both its one house budgets and at the negotiating table.

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The NYCLU thanks the legislature for the opportunity to provide testimony and for your work on the budget.

va/2020/07/17/black-anti-vaccine-coronavirus-tuskegee-syphilis/?hpid=hp_hp-banner-main_black-antivax-940am%3Ahomepage%2Fstory-ans.

[39] *See* Felicia Schanche Hodge, *No Meaningful Apology for American Indian Unethical Research Abuses*, 22 ETHICS & BEHAVIOR 431 (2012).

[40] Katherine Andrews, *The Dark History of Forced Sterilization of Latina Women*, UNIV. OF PITTSBURGH, Oct. 30, 2017, https://www.panoramas.pitt.edu/health-and-society/dark-history-forced-sterilization-latina-women.

[41] Caitlin Dickerson, Seth Freed Wessler, & Miriam Jordan, *Immigrants Say They Were Pressured Into Unneeded Surgeries*, N.Y. TIMES, Sept. 29, 2020, https://www.nytimes.com/2020/09/29/us/ice-hysterectomies-surgeries-georgia.html.

[42] N.Y. Pub. Health §§ 2180 – 82 (McKinney).

[43] N.Y. Pub. Health §§ 2169, 2180, 2183 (McKinney).

[44] *Supra* p. 9 – 10.