

POSITIVE RIGHTS: THE NEW YORK “BABY AIDS BILL” AS
STATE-CREATED DANGER

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Abstract

The New York “Baby AIDS Bill” created a requirement for mandatory, unblind testing of newborns for HIV. This law, and its associated regulatory infrastructure, is contrary to a number of deeply rooted substantive due process rights, including the right to refuse life-sustaining treatment and the right to privacy and bodily autonomy. When the state requires that a physician initiate care or treatment, the government exposes itself to liability under the state-created danger doctrine, particularly when resistance-prone conditions like HIV are involved. In this unique situation, the state’s requirement to initiate antiretroviral care without providing for its continuity puts infants living with HIV at a significant risk of developing treatment resistance. One solution to this constitutionally problematic health policy is to recognize a positive right to health care for these infants, as a means of mitigating the danger so long as the unblind testing and treatment requirement exists.

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INTRODUCTION

Few areas of domestic policy in the United States have been as vigorously debated in the last decade as health care.¹ Ideologically, universal health care is an attractive policy, and establishing a basic level of care as a substantive right coheres with ideals of a continuously improving standard of living, resource conscious social welfare measures, and an aspirational regard for a decent quality of life.² However, mere ideological attractiveness has never been recognized as a sufficient basis for judicial or legislative recognition of a “new” substantive right, especially one that the government is to fully subsidize, like health care. This is not necessarily because of any moral deficit in the American conscience; rather, as Judge Richard Posner famously wrote, “the Constitution is a charter of negative rather than positive liberties.”³ In other words, U.S. citizens, by the structure and design of the government, are given freedoms *from*, rather than guaranteed any freedoms *to*.⁴

To this end, American jurisprudence has routinely denied positive rights to citizens.⁵ Nonetheless, there exist two types of factual scenarios where a citizen has successfully won recognition of a positive liberty from the courts. The first is when the citizen has the status of a ward (typically incarcerated) and, being in state custody, is reliant on the state

1. The recent 2016 election is one example of this issue. No candidate offered a blanket endorsement of President Obama’s health care bill as passed in 2010. Central to the health care debate was the question of whether the United States was ready to embrace health care as a fundamental right for all Americans. Only Senator Bernie Sanders’s proposal for universal health care answered this question affirmatively. See Robert D. Reischauer & Alice M. Rivlin, *Health Policy Issues and the 2016 Presidential Election*, BROOKINGS INST. (Nov. 18, 2015), <https://www.brookings.edu/research/health-policy-issues-and-the-2016-presidential-election/> [<https://perma.cc/H2RK-8KJP>]; see also Alison Kodjak, *All Things Considered: Platform Check: Trump and Clinton on Health Care*, NPR (Nov. 2, 2016), <https://www.npr.org/2016/11/02/500371785/platform-check-trump-and-clinton-on-health-care> [<https://perma.cc/HG34-2F7G>].

2. Allen E. Buchanan, *The Right to a Decent Minimum of Health Care*, 13 PHIL. & PUB. AFF. 55, 58–59 (1984).

3. *Jackson v. City of Joliet*, 715 F.2d 1200, 1203 (7th Cir. 1983).

4. David P. Currie, *Positive and Negative Constitutional Rights*, 53 U. CHI. L. REV. 864, 866 (1986).

5. See, e.g., *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 35 (1973) (“Education, of course, is not among the rights afforded explicit protection under our Federal Constitution. Nor do we find any basis for saying it is implicitly so protected.”); *Jackson*, 715 F.2d at 1204 (“[A]s currently understood, the concept of liberty in the Fourteenth Amendment does not include a right to basic services, whether competently provided or otherwise.”).

to affirmatively provide certain benefits,⁶ such as basic medical care.⁷ The second is closely related, and arises when a state actor acts affirmatively to place a citizen in circumstances that leave the citizen worse off than had the state not acted at all.⁸ Under this precedent, there are few possible factual scenarios where the state (or even the federal government) would create an obligation to provide health care for a citizen.

In 1993, New York State legislature introduced a public health bill that would position a narrow and unlikely population to potentially assert that the government assumed an obligation to provide care: HIV-positive babies. After nearly a decade of seeing acquired immunodeficiency syndrome (AIDS) take more than 510,000 lives,⁹ New York emerged as a leader in health policy in the late 1980s. State and municipal health agencies in New York worked to aggressively curtail the spread of the human immunodeficiency virus (HIV), which researchers had found was the pathological cause of developing AIDS.¹⁰ New York, like many states, adopted—as one means of monitoring the prevalence of HIV—the mandatory blind testing of all newborns in a piece of legislation called the “Baby AIDS Bill.”¹¹ The effect of the original bill was purely statistical monitoring with no bridge to treatment.¹² Finding this unacceptable, Assemblywoman Nettie Mayersohn led the charge to not only remove the blind testing provision, but also to ensure treatment of those infants who have a positive serostatus (indicating HIV+ status through the presence of antibodies).¹³ Amidst a widely publicized debate

6. *Youngberg v. Romeo*, 457 U.S. 307, 324–25 (1982) (holding that the state is responsible for the safety of individuals in its custody or care).

7. Currie, *supra* note 4, at 874.

8. *White v. Rochford*, 592 F.2d 381, 383 (7th Cir. 1979).

9. Ctrs. for Disease Control & Prevention, *HIV and AIDS—United States, 1981–2000*, 50 MMWR WEEKLY 430, 431 (2001), <https://www.cdc.gov/mmwr/PDF/wk/mm5021.pdf> [<https://perma.cc/64SC-M4GJ>].

10. See generally N.Y. STATE DEP’T OF HEALTH AIDS INST., JULY 30, 1983–JULY 30, 2008: 25 YEARS OF LEADERSHIP, SERVICE AND COMPASSION (2010) (describing New York State’s response to the HIV/AIDS epidemic starting in the early 1980s).

11. Nettie Mayersohn, *The “Baby AIDS” Bill*, 24 FORDHAM URB. L.J. 721, 721–22 (1997).

12. See, e.g., *id.* at 722 (“[W]hen a newborn tested positive, nothing was done to get the infants into treatment.”).

13. *HIV/AIDS Glossary: Serostatus*, U.S. DEP’T. HEALTH & HUM. SERVS.: AIDS INFO, <https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/1632/serostatus> [<https://perma.cc/Z5BX-GYBQ>] (last updated Nov. 19, 2018). Serostatus is the clinical term for a person’s HIV status. All babies born to HIV-positive mothers will have a positive serostatus at birth, since they have temporarily inherited antibodies from their mothers’ immune systems while their own develops. See WORLD HEALTH ORG., *HIV/AIDS PROGRAMME: WHO RECOMMENDATIONS ON THE DIAGNOSIS OF HIV INFECTION IN INFANTS AND CHILDREN* 30 (2010). Because of this, it takes eighteen months to determine whether the baby is independently HIV-positive. See *id.*; see also

over privacy rights of mothers, their partners, and children, Mayersohn succeeded in securing unblind testing of infants and their mothers.¹⁴

Since 1997, the health care community has learned much about HIV treatment and prevention. When mothers know their serostatus, transmission of the virus can be almost certainly prevented.¹⁵ The scientific community has also learned that HIV medications may become ineffective over the course of a person's lifetime, especially if care is discontinuous.¹⁶ Therefore, the question surfaces: if New York has a statutory requirement for the "responsible physician" to initiate health care for HIV-positive newborns,¹⁷ is New York establishing a right for infants to receive health care related to treatment and maintenance of HIV from the state?

To answer this question, Part I will examine the judicial history of how fundamental liberties are established by exploring substantive due process in the context of medical rights. It will also identify the scant positive rights that have been recognized in state protection and state-created danger cases. It will argue that through rulings on reproductive rights, medical aid-in-dying, and state-created danger cases, the courts have created precedent that makes the current Baby AIDS Bill untenable and unconstitutional.

Part II will explore the legislative history and intent behind the Baby AIDS Bill and discuss some of its medical implications. It will argue that, under current substantive due process and state-created danger doctrines, the circumstances created by the regulations of the Baby AIDS Bill are factually and legally situated to establish a positive right to health care in newborns who receive mandatory treatment for their HIV-positive status without express consent from their mothers. This bill and regulation, the state temporarily supplants the parent in making health care decisions for the child, induces reliance on a therapy, and then fails to provide for its

Mayersohn, *supra* note 11, at 726 ("By relying on blinded testing, we are in no way protecting women. Women need to know as soon as possible about their own condition and that of their babies so they can make immediate healthcare decisions; so they can make decisions on future pregnancies; so they can make arrangements for the care of their children if or when they, themselves, can no longer care for them.").

14. Mayersohn, *supra* note 11, at 727.

15. *Preventing Mother-to-Child Transmission of HIV*, U.S. DEP'T. OF HEALTH & HUMAN SERVS.: AIDS INFO, <https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/20/50/preventing-mother-to-child-transmission-of-hiv> [<https://perma.cc/XC6Z-FN6R>] (last updated May 24, 2018).

16. C. Holkmann Olsen, et al., *Interruption of Combination Antiretroviral Therapy and Risk of Clinical Disease Progression to AIDS or Death*, 8 HIV MED. 96, 96 (2007).

17. N.Y. COMP. CODES R. & REGS. tit. 10, § 69-1.5 (2018). This section of the public health regulations also applies to other illnesses that may be present but initially undetectable at birth. HIV is unique in that beginning treatment and then stopping treatment may make it harder to manage later on. See Olsen, et al., *supra* note 16.

continuity. This Note proposes that recognizing a positive right to health care is one means of preserving the positive aspects of the Baby AIDS Bill without merely creating a different risk of harm through treatment. This Note will conclude with a brief examination of the policy implications of recognizing a positive right to health care in newborns treated for HIV.

I. SUBSTANTIVE DUE PROCESS FOSTERS LIMITED LIBERTIES IN HEALTH CARE

To discuss contemporary positive rights jurisprudence, it is necessary to understand the basic political philosophy of rights as they were construed in the drafting of the Constitution and the Bill of Rights. Three decades prior to the drafting of these documents, Thomas Jefferson described the Enlightenment view of rights as “immutable,” “inalienable,” and “natural”¹⁸ in the Declaration of Independence, recognizing also that a government was essential to secure them.¹⁹ Contrary to early interpretations of the Constitution, the classical liberalism with which Jefferson crafted the Declaration and influenced the framers did not exclude social and economic rights—those most often seen as “positive rights.”²⁰

By 1868, when the Fourteenth Amendment was ratified, rigid originalism had become much less workable as changes in culture, society, and politics helped show that some “rights” anticipated by the Constitution were more reasonably “a constitutionally guaranteed . . . sphere of individual liberty” and therefore not so flat and immutable.²¹ Courts could expand (or contract) what was encompassed by or implicit in a right or liberty through the provisions of the Fourteenth Amendment. Specifically, Section I of the Fourteenth Amendment—another set of negative liberties—introduced three protected rights that would become integral in fostering the contemporary American welfare state: the Privileges and Immunities Clause; the Equal Protection Clause; and, of interest to this Note, the Due Process Clause.²² These new protections were implemented in the wake of the American Civil War,

18. C.J. Friedrich, *Rights, Liberties, Freedoms*, 91 U. PA. L. REV. 312, 312 (1943).

19. THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776).

20. Cass R. Sunstein, *Why Does the American Constitution Lack Social and Economic Guarantees?*, 56 SYRACUSE L. REV. 1, 9 (2005).

21. Friedrich, *supra* note 18.

22. U.S. CONST. amend. XIV, § 1. Due process was first tested in the *Slaughter-House Cases*, where a state-created monopoly was awarded to one meat processor, and other meat processors claimed that they were therefore deprived of economic liberty. The *Slaughter-House Cases*, 83 U.S. 36, 57–62 (1872). The claim was denied on the grounds that the Fourteenth Amendment only protected *procedural* due process rights, and that economic liberties were thus not included. *See id.* at 80–81.

where the breakthrough of emancipation nominally precipitated a dramatic expansion of the population that was afforded civil liberties, at least by the Federal Government.²³

While initially viewed as a procedural protection, the Due Process Clause came to serve as the mechanism for defining new ideas “implicit in the concept of ordered liberty.”²⁴ As the doctrine of substantive due process evolved over the course of the twentieth century, individuals began to challenge the perception that fundamental liberties functioned only as guarantees that the government could not infringe upon certain rights of its citizens. With the abolition of slavery, the enfranchisement of women, and the rapid expansion of the welfare state under the New Deal, it was simply less realistic that a growing, wealthy nation could remain committed to the narrow Bill of Rights, or at least decline to expand what these essential rights included.²⁵

This judicial right-making is not without extreme risks in the health care context. When the government endeavors to assume more responsibility for providing health care, it induces more reliance from those provided for—a message clearly implicit in *National Federation of Independent Business v. Sebelius*²⁶ (discussed below).²⁷ Subsequently, the government will find it more difficult to back away from this responsibility—even if no legal obligation actually exists. So far, the Supreme Court has maintained strict active-passive and positive-negative distinctions in health care rights.²⁸ First, the Court has *recognized* bodily autonomy and the right to privacy by finding a fundamental liberty interest in the right to abortion and contraception.²⁹ These are negative liberties, preventing state and federal governments from interfering with choice in reproductive care.³⁰ Second, the Court has *declined to recognize* a fundamental right to medical aid-in-dying, while *upholding* a right to deny life-sustaining treatment.³¹ In these cases, the Court made a means-based distinction that allowed passive means to hasten death, but upheld bans on physician assistance.³² Finally, the Court has held that loss of

23. Eugene Gressman, *The Unhappy History of Civil Rights Legislation*, 50 MICH. L. REV. 1323, 1323–24 (1952).

24. *Palko v. Connecticut*, 302 U.S. 319, 325 (1937).

25. See *Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting) (arguing, in dissent, that in evaluating whether something is a fundamental right, the Court should consider how society is breaking with tradition).

26. 567 U.S. 519 (2012).

27. *Infra* Section I.C.

28. *Infra* Section I.B.

29. *Infra* Section I.A.

30. *Infra* Section I.A.

31. *Infra* Section I.B.

32. *Infra* Section I.B.

Medicare funding under certain Patient Protection and Affordable Care Act (PPACA) provisions would be unconscionable.³³ This decision implicitly charted a basis for a right to health care when the government has substantially induced reliance on it.

The idea of government liability resulting from induced reliance bears substantial resemblance to the states' liability to protect citizens when a state has created danger.³⁴ This latter concept of liability, considered alongside substantive due process rights in health care—the right to choice and bodily autonomy, the right to privacy, and the right to be free from forced treatment—provides a framework for legally recognizing a positive right to health care when the state creates harm through mandatory medical intervention. This Note will argue that the Baby AIDS Bill invokes these rights, and that in order to withstand scrutiny, New York State must provide for long-term health care related to HIV treatment in order to justify the constitutional complications and prevent future harm to newborns who are treated under this regulation.

A. *Abortion-Related Medical Rights Under Substantive Due Process*

Though perhaps not evident at the time, the Supreme Court's earliest substantive due process decisions relating to contraception and abortion have had strong implications for health care. The Court found a right to privacy both necessary for ordered liberty and profoundly embedded in our history and tradition, and also found that reproductive health care and the decision to procreate were included in this right.³⁵ The rights to choice and privacy are inextricable from modern care, where patient consent and the protection of health information are paramount in the doctor-patient relationship.

Privacy as a fundamental right was first articulated in *Olmstead v. United States*,³⁶ a case involving a criminal conviction based on evidence obtained illegally by wiretapping carried out by federal agents.³⁷ Only Justice Louis Brandeis found this invasion of privacy dangerous enough to dissent.³⁸ Speaking of the framers, he said: "They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men."³⁹ This dissent was the

33. *Infra* Section I.C.

34. *Infra* Section I.D.

35. *See, e.g.*, *Griswold v. Connecticut*, 381 U.S. 479, 494 (1965) (Goldberg, J., concurring) (declaring a fundamental right to marital privacy that included the ability to seek contraception).

36. 277 U.S. 438 (1928).

37. *Id.* at 455–57.

38. *Id.* at 471 (Brandeis, J., dissenting).

39. *Id.* at 478.

springboard for a much more abstract notion of privacy nearly four decades later in *Griswold v. Connecticut*.⁴⁰

In *Griswold*, the Court demonstrated that one method of negotiating new rights was finding ways to define them as implicit in existing ones.⁴¹ *Griswold* involved a Connecticut statute that prevented couples from acquiring oral contraceptives, a law that a majority of the Supreme Court found to be offensively intrusive to marital privacy⁴² and the concurrence found to be pernicious to public health knowledge and education.⁴³ Still, the privacy right first conceived of in *Olmstead*,⁴⁴ then solidified in *Griswold*, was a negative right that prohibited rather than required government action.

Following *Griswold*, in the early 1970s, citizens attempted to assert rights they believed were implicit to ordered liberty in minimum subsistence,⁴⁵ housing,⁴⁶ and education.⁴⁷ The Court denied all of these, indicating that while the judiciary was ready to *consider* that more rights were fundamental than those explicitly stated in the Constitution, the extent to which those rights were entitlements to governmental guarantees significantly lessened the likelihood of recognition.⁴⁸ Nowhere was this more evident than *Roe v. Wade*⁴⁹ and its progeny, where, over the next twenty years, the court increasingly recognized rights of bodily autonomy and choice⁵⁰ but limited the government's

40. 381 U.S. at 494 (Goldberg, J., concurring).

41. *Id.* at 483 (majority opinion). In this opinion, Justice William Douglas notably introduced the current concept of the “penumbra” of rights that has become inextricable from the substantive due process doctrine. *Id.* at 484. His identification of a right to privacy in declaring unconstitutional a law preventing access to contraception was a watershed moment in identifying and articulating other previously unrecognized rights.

42. *Id.* at 485–86. Justice Douglas famously questioned: “Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives? The very idea is repulsive to the notions of privacy surrounding the marriage relationship.” *Id.*

43. *Id.* at 503 (White, J., concurring).

44. 277 U.S. at 478 (Brandeis, J., dissenting) (“They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men.”).

45. *Dandridge v. Williams*, 397 U.S. 471, 478–83 (1970). This case was decided on grounds of equal protection, but nonetheless considered the right similarly when determining that discriminatory classification could be justified by a mere rational basis. *Id.* at 483.

46. *Lindsey v. Normet*, 405 U.S. 56, 74 (1972).

47. *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 35 (1973).

48. *See Rodriguez*, 411 U.S. at 35; *Lindsey*, 405 U.S. at 74; *Dandridge*, 397 U.S. at 485.

49. 410 U.S. 113 (1973).

50. *See id.* at 154; *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 846 (1992) (affirming the right to an abortion recognized in *Roe* under a viability standard, but allowing ancillary requirements to stand).

obligation to facilitate abortion through federally funded programs.⁵¹ The *Roe* decision was a balancing act of cognizable rights of mother and fetus under the Constitution, striving to set bright-line trimester rules for medically tenuous circumstances.⁵² The viability approach was largely a matter of comity, with the Court stating, “the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.”⁵³

Subsequent contested abortion litigation resulted in the refinement of the limits of the fundamental right and the reinforcement of viability determinations.⁵⁴ Presently, states are not allowed to impose an “undue burden” on women seeking an abortion, but states are able to impose limits once fetal viability is established.⁵⁵ *Roe* stands as one of the first substantive due process cases where the Supreme Court encountered rights so closely entwined with contemporary notions of health care, and the territory it secured has remained constant. Even in conservative repeal efforts, proposals have often carved out exceptions for medically necessary, post-viability abortions, further demarcating the government’s territory of interest in leaving untouched certain realms of decisions involving health-related issues.

Seven years after *Roe*, the Court drew clear lines in positive rights jurisprudence and health care entitlements when it considered whether federal medical insurance programs were required to pay for childbirth or abortion in *Harris v. McRae*.⁵⁶ In a narrow 5-4 decision, the Court upheld the still contentious Hyde Amendment⁵⁷ and decided that the rights extrapolated in *Roe* did not confer on a woman “a constitutional entitlement to the financial resources to avail herself of the full range of protected choices.”⁵⁸ This split Court foreshadowed equivocation on the future of recognizing rights related to self-determination in health care and the government’s role in securing care. In *Harris*, the government

51. *Harris v. McRae*, 448 U.S. 297, 318 (1980) (denying a claim for Medicaid funding for both childbirth and abortion on the grounds that the government is not required to subsidize any medical care).

52. *Roe*, 410 U.S. at 164–66.

53. B. Jessie Hill, *Reproductive Rights as Health Care Rights*, 18 COLUM. J. GENDER & L. 501, 508 (2009) (emphasis omitted) (quoting *Roe*, 410 U.S. at 166).

54. *Casey*, 505 U.S. at 869–70 (abandoning the rigid trimester approach established by *Roe*); see also *Gonzales v. Carhart*, 550 U.S. 124, 156 (2007) (upholding a ban on partial-birth abortion); *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 515, 522 (1989) (upholding a state statute requiring physicians to determine fetal viability prior to performing an abortion).

55. *Casey*, 505 U.S. at 846.

56. 448 U.S. 297, 318 (1980).

57. At the time of writing this Note, there is currently legislation before Congress that would make the ban on federal funding for abortion permanent. See No Taxpayer Funding for Abortion Act, H.R. 7, 115th Cong. § 301 (2017).

58. *Harris*, 448 U.S. at 316.

asserted a sound rational basis in refusing to extend Medicaid coverage to abortion.⁵⁹ That basis was the history of negative liberties jurisprudence, which had consistently held that while the government cannot be the source of burden in exercising a right, the government has no obligation to do anything about those obstacles it did not impose.⁶⁰ Implicit in this reasoning is the suggestion that, no matter how expansive negative liberties may be, it is possible that the government may, by an affirmative act, create a duty to remove an obstacle it *does* create.

B. *Health Care Rights Limited: No Right to Die*

Roe and its progeny represent a progressive expansion of rights as they relate to affirming bodily autonomy and self-determination, rooted in a right to privacy. Paradoxically, due process rights rooted in privacy are by definition devoid of government action and personal entitlement. States, therefore, are only required to protect such rights, not facilitate them.⁶¹ While there has been no shortage of challenges to the holding in *Roe* and, more recently, *Planned Parenthood of Southeastern Pennsylvania v. Casey*,⁶² the privacy interests recognized in these cases remain guiding precedent and have secured a litany of other rights for families and couples.⁶³

In the health care context, however, the Court has demonstrated inconsistencies in its approach to liberties in medical treatment, particularly when the treatment is life-sustaining. The New Jersey Supreme Court was the first court to seriously consider whether the breadth of the right to privacy encompassed a right to refuse life-sustaining medical treatment. In *In re Quinlan*, Karen Ann Quinlan's parents asserted that artificial respiration was an extraordinary means of preservation and petitioned to end the life-sustaining treatment.⁶⁴ They believed Quinlan should have a natural, passive death.⁶⁵ The question arose whether removing the respirator was equivalent to homicide.⁶⁶ The New Jersey Supreme Court ultimately ruled in favor of Quinlan's

59. *Id.*

60. *Id.* at 325.

61. See *Jackson v. City of Joliet*, 715 F.2d 1200, 1203 (7th Cir. 1983) (“[T]he Constitution is a charter of negative rather than positive liberties.”).

62. 505 U.S. 833 (1992).

63. See, e.g., *Obergefell v. Hodges*, 135 S. Ct. 2584, 2608 (2015) (conferring the fundamental right to marry on same-sex couples); *Windsor v. U.S.*, 570 U.S. 744, 774–75 (2013) (applying federal benefits to same-sex unions); *Lawrence v. Texas*, 539 U.S. 558, 578 (2003) (overruling the criminalization of same-sex sodomy in *Bowers v. Hardwick*, 478 U.S. 186 (1986)).

64. *In re Quinlan*, 355 A.2d 647, 657 (N.J. 1976).

65. *Id.*

66. *Id.* at 669–70.

family,⁶⁷ and five years later, the New York Court of Appeals rendered a similar decision in *In re Eichner*⁶⁸ with the added criteria of clear and convincing evidence that the patient would not have wanted such life-sustaining treatment.⁶⁹

In 1990, when the Supreme Court of the United States first considered the issue in *Cruzan v. Director, Missouri Department of Health*,⁷⁰ another 5-4 split left an additional tenuous holding in the sphere of health care liberties.⁷¹ In *Cruzan*, the Court ruled in accordance with the court in *Eichner* that clear and convincing evidence of patient preference was needed to cease life-sustaining treatment for the patient in a persistent vegetative state.⁷² The Court reached this decision by implicitly upholding a recognized fundamental liberty interest in refusing life-sustaining treatment, but the narrow framing of the question resulted in an opinion that only set forth a required standard of clear and convincing evidence in cases where the patient is not competent to decline treatment.⁷³

If the *Cruzan* holding was not satisfactory to physicians and patients seeking to articulate a right to assistance in ending life, the subsequent attempts on equal protection grounds in *Vacco v. Quill*⁷⁴ and on due process grounds in *Washington v. Glucksberg*⁷⁵ offered no greater resolution. The *Vacco* Court, in addressing a New York State ban on physician-assisted suicide, reasoned that the only guarantee of equal protection was that similarly situated persons be treated similarly.⁷⁶ Therefore, as long as all competent terminally ill people were both able to refuse life-sustaining treatment and unable to receive treatment hastening death, there was no violation of the Fourteenth Amendment.⁷⁷ In *Glucksberg*, the Court denied the right to die without equivocation in a unanimous decision, finding a rational basis in Washington State's desire to preserve the integrity of the medical profession and in its aversion to policies that supported euthanasia.⁷⁸

While neither *Cruzan*, *Vacco*, nor *Glucksberg* declared any sort of permanent ban on the medical right to die, in no case did the Justices find

67. *Id.* at 669.

68. 420 N.E.2d 64 (N.Y. App. Div. 1981).

69. *Id.* at 72.

70. 497 U.S. 261 (1990).

71. *Id.* at 263.

72. *Id.* at 280.

73. *Id.* at 261, 283.

74. 521 U.S. 793 (1997).

75. 521 U.S. 702 (1997).

76. 521 U.S. at 798–99.

77. *Id.*

78. 521 U.S. at 728.

that there was any national “history or tradition” to support this being considered a right.⁷⁹ Since then, however, seven states and the District of Columbia have legislatively or judicially established a right to medical aid-in-dying, indicating an emerging history of health care liberties at the end of life.⁸⁰

Medical aid-in-dying litigation illuminates a critical inconsistency in the Supreme Court’s position on the nature of fundamental rights it recognizes in health care. The ruling that a competent terminally ill patient may not invoke the help of a physician in hastening death is nearly untenable when the Court has also said that a person may choose the passive means of hastening death by refusing treatment.⁸¹ This position reflects a history of negative rights jurisprudence, under which the government may not require a citizen to accept life-sustaining treatment without committing battery.⁸² Had the government required acceptance of treatment, it almost certainly would have created an entitlement to subsidized health care for all, lest economically disadvantaged citizens be unable to comply.

Scholars have framed the dispute regarding medical aid-in-dying as a conflict of perceived “self-sovereignty” derived from both the Fourteenth Amendment and broader policy concerns regarding the sanctity of life and potential abuses.⁸³ Proponents of the current policy cast Chief Justice William Rehnquist’s rulings in *Vacco* and *Glucksberg* as grounded in an incisive distinction of intent, quoting the Chief Justice’s analysis that there is a significant legal difference “between a person who knows that another person will be killed as the result of his conduct and a person who acts with the specific purpose of taking another’s life.”⁸⁴ This analysis hardly resolves the inconsistency at any essential level, but it does indicate that the degree to which a right is positive—that is, the extent to which a right demands government action—is perhaps less determinative than it once was.

Others have argued that *Glucksberg* phrased the issue narrowly as a matter of convenience, even though the essence of the right in question—the right to bodily autonomy—was well established and well protected

79. See, e.g., *id.* (“The history of the law’s treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it.”).

80. *Take Action: States with Dignity Laws*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/take-action/> [<https://perma.cc/AQB6-GYFH>] (last updated Nov. 12, 2018) [<https://perma.cc/B37D-PHZF>].

81. *Glucksberg*, 521 U.S. at 725.

82. *Id.*

83. See, e.g., Neil M. Gorsuch, *The Right to Assisted Suicide and Euthanasia*, 23 HARV. J.L. & PUB. POL’Y 599, 614–15 (2000).

84. *Id.* (quoting *Vacco v. Quill*, 521 U.S. 793, 802 (1997)).

by the time medical aid-in-dying surfaced in the courts.⁸⁵ Rehnquist's analysis was based on an exceptionally strict application of the "history and tradition" element of fundamental rights, leading to the conclusion that there had been only a history of *rejecting* suicide in any form.⁸⁶ This factor, of course, is only part of the consideration in determining whether a fundamental right exists, but substantive due process doctrine has routinely shown that history and tradition are subject to rapid changes in opinion.⁸⁷ The Supreme Court has already recognized, to some degree, that the federal government's subsidization of health care has become inextricable from the national health system, indicating at least the nascence of an emerging tradition.

C. Government Obligation and the Patient Protection and Affordable Care Act

Most recently, the Supreme Court indicated in *National Federation of Independent Business v. Sebelius*⁸⁸ that it is not wholly blind to an emerging history and tradition of state-sponsored health care when it struck down the Medicaid expansion requirements in the Patient Protection and Affordable Care Act (PPACA).⁸⁹ Congress cited to the taxing and spending power as its basis of authority for this provision of the PPACA.⁹⁰ However, the Supreme Court ruled that requiring the significant expenditures associated with Medicaid expansion were beyond the scope of Congress's power because it gave states an unimaginable ultimatum: expand Medicaid or lose the federal Medicaid subsidy.⁹¹ Strongly implicit in the Court's ruling is the conclusion that the government, by its own creation, funding, and maintenance of subsidized health care, has induced such substantial reliance on Medicaid

85. Erwin Chemerinsky, *Washington v. Glucksberg Was Tragically Wrong*, 106 MICH. L. REV. 1501, 1505 (2008).

86. *Id.*

87. See the discussion of *Bowers v. Hardwick*, 478 U.S. 186 (1986) in Darren Lenard Hutchinson, *Undignified: The Supreme Court, Racial Justice, and Dignity Claims*, 69 FLA. L. REV. 1, 9 (2017). When history and tradition are cited as grounds for a decision, particularly in justifying an especially conservative ruling, it often mobilizes advocacy efforts that spur the emergence of new tradition. Such was the case between 1986, when *Bowers* upheld anti-sodomy laws, and 2003, when the Supreme Court overturned its decision in *Bowers* in *Lawrence v. Texas*. *Id.*

88. 567 U.S. 519 (2012).

89. *Id.* at 585.

90. Jack M. Beermann, *NFIB v. Sebelius and the Right to Health Care: Government's Obligation to Provide for the Health, Safety, and Welfare of Its Citizens*, 18 N.Y.U. J. LEGIS. & PUB. POL'Y 277, 284 (2015).

91. *Sebelius*, 567 U.S. at 585.

services that conditional spending tied to drastic changes to Medicaid was unconscionable.⁹²

The relationship between the provision of health care and fundamental rights remains uncertain. By rejecting the penalty to states that declined to expand Medicaid, the *Sebelius* decision casts a shadow on earlier cases that enshrine the negative framing of the Constitution.

D. *State Protection and the Haven of Positive Rights*

There are few places in common law where positive rights and extraordinary affirmative duties *are* found. Tort law does not hold the nonfeasor liable, nor does criminal law punish the passive observer of a homicide (unless some duty is created or exists).⁹³ Some tenets of contract law alone, wherein citizens can seek support from the judiciary in enforcing things contracted for, suggest positive rights.⁹⁴ American legal traditions are saturated with proscriptive rules that tell individuals and institutions (including the state and federal governments) what they cannot do, not what they must do.⁹⁵

State protection of citizens from violence against one another may be characterized as the most fundamental purpose of government,⁹⁶ but the Supreme Court has routinely declined to impose this duty on the state.⁹⁷ The *DeShaney v. Winnebago County Department of Social Services*⁹⁸ opinion remains one of the most influential decisions in charting out the extent of government obligations to prevent private wrongs. *DeShaney* thereby conceptualizes a positive right to state protection, although the

92. Beermann, *supra* note 90, at 287. Beermann observes: “The expectation that government will provide medical care for those who cannot afford it is so ingrained in the mind of Americans that while adjustments can be made in light of changing policy and available resources, wholesale abandonment of the duty is unthinkable.” *Id.*

93. See RESTATEMENT (SECOND) OF TORTS § 302 cmt. a (AM. LAW INST. 1965) (“The duties of one who merely omits to act are more restricted, and in general are confined to situations where there is a special relation between the actor and the other which gives rise to [a] duty.”); Alison McIntyre, *Guilty Bystanders? On the Legitimacy of Duty to Rescue Statutes*, 23 PHIL. & PUB. AFF. 157, 157 (1994) (“In most jurisdictions in the United States, if you fail to assist or obtain assistance for a stranger in grave peril when you could do so easily and without significant risk to yourself, your conduct does not constitute even a minor criminal offense.”).

94. Currie, *supra* note 4, at 874.

95. See Michael J. DeBoer, *Legislating Morality Progressively—The Contraceptive Coverage Mandate, Religious Freedom, and Public Health Policy and Ethics*, 28 J.L. & HEALTH 62, 84 n.144 (2015) (“Government is held solely to what courts characterize as a negative obligation: to refrain from acts that deprive citizens of protected rights.”).

96. David A. Strauss, *Due Process, Government Inaction, and Private Wrongs*, 1989 SUP. CT. REV. 53, 53.

97. See, e.g., *DeShaney v. Winnebago Cty. Dep’t of Social Servs.*, 489 U.S. 189, 200 (1989).

98. 489 U.S. 189 (1989).

Court did not explicitly hold such a right was invoked in that case.⁹⁹ The case involved severe abuse of a young child, Joshua DeShaney, by his father, who had sole custody.¹⁰⁰ DeShaney was treated multiple times for abuse-related injuries, and a social worker from the Department of Social Services comprehensively detailed suspicions that DeShaney's father was abusing him.¹⁰¹ The Department took no action and eventually the abuse grew so severe that DeShaney was beaten into a coma and left with lifelong traumatic brain injuries.¹⁰² His mother sued in a § 1983 action, but the Supreme Court declined to recognize that the Department had an obligation to protect DeShaney since he was in his father's care.¹⁰³ The Court distinguished this case from other cases where the Court had found a right to state protection, namely in the context of wards—typically either incarcerated individuals¹⁰⁴ or individuals in the state foster care system.¹⁰⁵ A majority opinion did not secure state immunity in *DeShaney*, and Chief Justice Rehnquist, who also authored the *Glucksberg* opinion, took care to maintain the active-passive distinction when suggesting what would invoke the requirement of some affirmative protective action by the state.¹⁰⁶ *DeShaney* established that physical custody by the government and risk created by the government would necessitate government protection.¹⁰⁷

DeShaney has not withstood exception, however. Since this decision in 1989, federal courts have grappled with whether state protection should be required when either a special relationship with the state or a state-created danger is present, or more narrowly, when both are present.¹⁰⁸ Across circuits, there are limited instances where an individual has successfully brought a § 1983 action for the deprivation of liberty in the state protection context. *Stemler v. City of Florence*¹⁰⁹ is one notable successful example. There, the court relied on the dicta in *DeShaney* and analogous cases to support a reversal of the district court's ruling that police officers did not deprive decedent Conni Black of her liberty when

99. *Id.* at 200.

100. *Id.* at 191.

101. *Id.* at 192–93.

102. *Id.* at 193.

103. *Id.* at 193–94.

104. *See, e.g., Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (finding that a state prison had violated the Eighth Amendment by demonstrating deliberate indifference to the serious medical needs of an incarcerated individual).

105. Strauss, *supra* note 96, at 55.

106. Erwin Chemerinsky, *The State-Created Danger Doctrine*, 23 *TOURO L. REV.* 1, 3 (2007).

107. *Id.*

108. *Id.* at 3–4.

109. 126 F.3d 856 (6th Cir. 1997).

they forced her to leave the scene with her abuser.¹¹⁰ In Black's situation, custody was certain, but the *Stemler* court went out of its way to note the emerging existence of a duty of care when the state has merely created a risk of harm without the individual being in custody (that is, being a ward).¹¹¹

The *Stemler* court used the dicta from *Gazette v. City of Pontiac*¹¹² to characterize the creation of this duty: "[A] duty to protect can arise in a noncustodial setting if the state does anything to render an individual more vulnerable to danger."¹¹³ The Sixth Circuit's articulation of the state-created danger doctrine in *Stemler* was a powerful starting point for the development of a plaintiff-friendly theory of liability, and since then, some courts have conformed the test more closely to traditional notions of tort liability by calling the state actor the "but-for" cause of the harm.¹¹⁴ Circuits have offered various tests for the state-created danger doctrine, though requirements for plaintiffs to prove that the government action "shocks the conscience" or put the plaintiff at greater risk than the general public problematize the tests to the point of nullity.¹¹⁵

Among the areas of constitutionality implicated by the laws and regulations that this Note will proceed to discuss, state protection's shaping of positive rights jurisprudence is perhaps the most influential and certainly the most unsettled. The Baby AIDS Bill exists at an intersection of Supreme Court doctrine, creating challenging questions about the primacy of certain liberty interests, potential harms created by health care intervention, and the statutory allowance—and requirement—of actions that violate personal autonomy and may create a danger to infants born with HIV. If the Bill is to survive the scrutiny that many have argued it should be subjected to regarding liberty interests, it is necessary to answer the question of whether New York has created the type of harm protected against by the Constitution by failing to provide permanent health care for infants who are born HIV positive and treated from birth.¹¹⁶

110. *Id.* at 866–70.

111. *Id.* at 868.

112. 41 F.3d 1061, 1065 (6th Cir. 1994).

113. *Stemler*, 126 F.3d at 868 (quoting *Gazette*, 41 F.3d at 1065).

114. Chemerinsky, *supra* note 106, at 10. Chemerinsky identifies *Currier v. Doran*, 242 F.3d 905 (10th Cir. 2011) as one of the most pro-plaintiff decisions. *Id.* He posits that if cases like *DeShaney* had been decided under the *Currier* test, liability for the government would have been much easier to prove. *Id.*

115. *Id.* at 15–17.

116. See Gina A. Angellea, *New York Public Health Law § 2500-F: The Hand That Robbed the Cradle of Privacy*, 18 ST. JOHN'S J. LEGAL COMMENT. 175, 177 (2003); Kelly D. Bryce, *Mandatory HIV Testing of Newborns: Is There a Better Way to Achieve the State's Goal of Preventing Transmission of HIV to Newborns and Ensuring them Treatment*, 4 QUINNIPIAC

II. THE HISTORY OF THE NEW YORK BABY AIDS BILL

The genesis of HIV/AIDS in the United States is memorialized mostly by vague journalistic pieces and the Center for Disease Control and Prevention's (CDC) *Morbidity and Mortality Weekly Report*. Some journalistic accounts have attempted to weave these together to reconstruct the narrative through the limited and confusing facts available from the early days of the epidemic.¹¹⁷ Public health data from that time indicate that San Francisco, New York, and, to a lesser extent, Los Angeles were the settings where significant numbers of gay men started showing up in hospitals with Kaposi's sarcoma lesions and obliterated immune systems.¹¹⁸ It was not long before other populations, including intravenous drug users, Haitian immigrants, hemophiliacs, and infants, began to demonstrate similar symptoms.¹¹⁹ Thus, an epidemic was born.

A. *The Evolution of the Baby AIDS Bill*

By 1984, medical researchers knew with relative certainty that HIV was the cause of AIDS.¹²⁰ Within a year, the public health community had devised some methods for preventing transmission through diagnosis awareness, tailored to the most affected populations.¹²¹ Without financial support from the federal government, municipalities barely managed to provide care and slow the spread of an unbridled epidemic through aggressive public health strategies.¹²²

HEALTH L.J. 69, 69 (2000); Erin Nicholson, *Mandatory HIV Testing of Pregnant Women: Public Health Policy Considerations and Alternatives*, 9 DUKE J. GENDER L. & POL'Y 175, 176 (2002).

117. See generally RANDY SHILTS, *AND THE BAND PLAYED ON: POLITICS, THE PEOPLE, AND THE AIDS EPIDEMIC* (1987). Shilts's journalistic composition is one of the most comprehensive histories of the AIDS epidemic in the 1980s, detailing the contributions of the major scientists, public health officials, politicians, and activists during the early years of AIDS.

118. See N.Y. STATE DEP'T OF HEALTH AIDS INST., *supra* note 10, at 1.

119. See *id.* at 3.

120. Robert C. Gallo & Luc Montagnier, *Retrospective: The Discovery of HIV as the Cause of AIDS*, 349 NEW ENGLAND J. MED. 2283, 2284 (2003).

121. *Id.*

122. E.g., Peter S. Arno, *The Nonprofit Sector's Response to the AIDS Epidemic: Community-Based Services in San Francisco*, 76 AM. J. PUB. HEALTH 1325, 1325–26 (1986). The earliest responses in San Francisco to the AIDS epidemic were from volunteer and nonprofit organizations, like the Shanti Project and San Francisco AIDS Foundation. *Id.* Their main focus was providing comfort care and emotional support, but educational programs were implemented to share what little was known about preventing HIV infection. *Id.* For a similar perspective on the gay men's health crisis in New York City, see Suzanne C. Ouellette Kobasa, *AIDS and Volunteer Associations: Perspectives on Social and Individual Change*, 68 MILBANK Q. 280, 280–84 (1990).

Among these strategies was the mandatory blind testing of newborns for HIV.¹²³ The blind testing requirement, a CDC-endorsed method by which doctors and public health scientists were exclusively seeking to monitor the prevalence of HIV in the general population, offered no mechanism to specifically identify HIV-positive infants and mothers.¹²⁴ In the forty-three states where the CDC funded this practice, the prevailing health policy favored protecting confidentiality and privacy rights, despite concerns that doctors were missing an opportunity to connect newborns and their mothers to care.¹²⁵ The theory seemed to be that confidential and blind testing was better than no testing at all. If rampant stigmatization of the gay community had taught health officials anything, it was that confidentiality was necessary for even voluntary testing programs to be successful, let alone mandatory ones.¹²⁶ Still, this meant that even though the likelihood of vertical transmission of HIV was relatively low compared to other means of transmission,¹²⁷ children with a positive serostatus and unknown prognosis were being sent home to HIV-positive mothers—without either knowing they carried the virus.

The confidentiality of the testing requirements did not go unchallenged. Throughout the early 1990s, a vocal contingency led by Assemblywoman Nettie Mayersohn saw confidentiality as a roadblock to actively saving the lives of women and children.¹²⁸ Mayersohn recognized the inequitable outcome of voluntary and blind testing policies wherein women and children were kept from knowing critical health information, seemingly in order to protect the identity of male partners.¹²⁹ Beginning in 1993, Mayersohn spearheaded an amendment to the public health code that would unblind the testing requirement.¹³⁰

123. Kristin E. Schleiter, *Testing Newborns for HIV*, 11 AM. MED. ASS'N J. ETHICS 969, 969–70 (2009).

124. Mayersohn, *supra* note 11.

125. *Id.*

126. David Abramson, *Passing the Test: New York's Newborn HIV Testing Policy, 1987–1997*, in REDUCING THE ODDS: PREVENTING PERINATAL TRANSMISSION OF HIV IN THE UNITED STATES 313, 316 (Michael A. Stoto et al. eds., 1999), <https://www.ncbi.nlm.nih.gov/books/NBK230554/> [<https://perma.cc/VXE2-DXVB>].

127. Marie-Louise Newell, *Prevention of Mother-to-Child Transmission of HIV: Challenges for the Current Decade*, 79 BULL. WORLD HEALTH ORG. 1138, 1138–39 (2001). All children born to HIV-positive mothers will test positive for HIV at birth because babies inherit their mother's immune systems and thereby inherit the HIV antibodies. See WORLD HEALTH ORG., *supra* note 13. However, approximately sixty to eighty-five percent of babies will not themselves become HIV-positive after about one-and-a-half to two years. Newell, *supra*, at 1138. The rate of actual vertical (also called perinatal and Mother-to-Child or MTC) transmission is inversely correlated to the prevalence of breastfeeding. *Id.*

128. Abramson, *supra* note 126, at 326.

129. *Id.* at 326–27.

130. Mayersohn, *supra* note 11.

What ensued was a contest of social, political, and scientific ideologies that were constantly influenced by changes in knowledge about the nature of and treatment for HIV.¹³¹

From 1994 to 1996, it seemed that Mayersohn's uncompromising position would have to make some concessions in light of lacking support and well-founded arguments from proponents of strictly voluntary unblind testing.¹³² However, party shifts in Congress, a landscape change in federal support of AIDS programs,¹³³ and political uncertainty in the New York State legislature dramatically altered the priorities for the New York Assembly.¹³⁴ This afforded Mayersohn the changes needed to pass the amended public health statute that would allow the implementation of mandatory unblind HIV testing of newborn children.¹³⁵ Governor George Pataki signed the Bill into law on June 26, 1996, and Public Health Commissioner Barbara DuBuono implemented the Bill, through regulations, on February 1, 1997, as part of the Comprehensive Newborn Testing Program.¹³⁶

In the 1990s, desperation and fear that the epidemic would never sufficiently abate made HIV/AIDS policies inherently exceptional in the fashion in which they were adopted, the vigor with which they were crafted, and the rules they sometimes broke. On the most practical level, Mayersohn's grassroots political campaign for an important public health issue appeared to be an appeal to common sense and good health care ethics. Thus, when Mayersohn's amendment was passed and implemented under New York Public Health Law § 2500-f, the mandatory unblind screening requirement took hold with little thought from the legislators about the implications for constitutional rights beyond those of confidentiality and privacy.

B. *The Constitutional Conundrum of the Baby AIDS Bill*

The law as implemented by DuBuono currently requires the testing of all newborn children in New York State, and the results must be

131. Abramson, *supra* note 126, at 328–35.

132. *Id.* at 331, 333.

133. See generally D. Parham & R. Conviser, *A Brief History of the Ryan White CARE Act in the USA and Its Implications for Other Countries*, 14 AIDS CARE S3, S4, S6 (2002). The mandatory testing of newborns was an anticipated requirement for states to receive Ryan White CARE Act funding upon its reauthorization in 1996. *Id.* States and urban centers alike, especially New York State, desperately needed this safety net funding to cover the costs of treatment and access to care, and thus many of the Ryan White mandates put an end to any discussion amongst state legislatures. *Id.*

134. Abramson, *supra* note 126, at 335.

135. *Id.*

136. *Id.*

communicated to the mother.¹³⁷ Of course, communicating the result of a positive serostatus is tantamount to telling a mother that she, too, is HIV-positive, a fact that she may or may not have known prior to giving birth or even conceiving.¹³⁸ The law also lists numerous duties of the “responsible physician,” including “provid[ing] or arrang[ing] for health care, case management and other social services as needed for the newborn.”¹³⁹ The constitutional concerns implicated by § 2500-f have been litigated and challenged on right-to-privacy grounds since the law’s inception, but most of the litigation has been limited to confidentiality and autonomy issues regarding the mother.¹⁴⁰

In mandating action contingent upon a positive HIV-test, the public health statute creates an obligation for care with few analogs found elsewhere in the law. Facially, it is unconstitutional, violating the rights of parents as the health care decisionmakers for their children. A mandatory test matched with mandatory treatment was a sensible public health strategy in 1996, but lawmakers could scarcely have anticipated all that scientists would discover about living with HIV, namely because living with HIV was tenuous at best.

Since the Bill was passed, medical researchers have learned much about living with, mitigating the effects of, and dramatically reducing the likelihood of vertically transmitting HIV.¹⁴¹ Currently, since HIV can only be managed and generally not cured, an HIV-positive individual is subject to *lifelong* therapy in order to reach a normal life expectancy.¹⁴² People living with HIV are treated with a regimen of antiretroviral drugs that can have harmful long-term effects on the body’s immune, endocrine, and excretory systems.¹⁴³ The virus may also develop immunity to an antiretroviral, particularly when treatment is discontinuous or interrupted.¹⁴⁴ It is this latter quality of developed resistance that makes the Baby AIDS Bill such a uniquely situated public health statute, rife with constitutional questions that concern both positive and negative liberties.

The Baby AIDS Bill can be analyzed by looking at its two constituent elements: testing and treatment. By mandating testing and treatment,

137. N.Y. COMP. CODES R. & REGS. tit. 10, § 69-1.5 (2018).

138. See Angellea, *supra* note 116, at 195–96.

139. N.Y. COMP. CODES R. & REGS. tit. 10, § 69-1.5.

140. See, e.g., Angellea, *supra* note 116, at 202, 204.

141. See generally *HIV Treatment: The Basics*, NAT’L INSTS. HEALTH, <https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/51/hiv-treatment--the-basics> [https://perma.cc/TKP3-4E6S] (last updated Mar. 22, 2018).

142. See Olsen et al., *supra* note 16, at 101–02.

143. Andrew Carr and David A. Cooper, *Adverse Effects of Antiretroviral Therapy*, 356 LANCET 1423, 1425–28 (2000).

144. Olsen et al., *supra* note 16, at 101–02.

physicians are authorized and required, on the one hand, to subject infants to testing regardless of parental consent. This screening is itself a practice that raises constitutional concerns about violating bodily autonomy and parental rights in child rearing.¹⁴⁵ It also deprives both mother and child of privacy rights without due process of law by ultimately disclosing the personal health information of no less than two individuals.¹⁴⁶ On this prong, however, the government would likely be able to articulate a compelling interest with no less restrictive means available; testing newborns for HIV is essential in addressing early health concerns of the baby and protecting public health at large.¹⁴⁷

If the outcome of the testing indicates that the child has HIV, the regulation corollary to the Bill requires the physician to disclose the results and *actively initiate care*.¹⁴⁸ The duty Public Health Law § 2500-f imposes on physicians establishes a state requirement anathema to the Supreme Court's doctrine on fundamental health care rights and is nearly alone in actively making physicians treat an individual. Under this regulation, New York is taking an affirmative action to subject an individual to life-prolonging treatment—an action directly at odds with medical aid-in-dying decisions and violative of the laws that protect against forceful acceptance of treatment.¹⁴⁹ The administration of antiretroviral drugs to an infant without consent, parental or otherwise, is conceivably battery and quite possibly deprivation of liberty without due process. If this law were challenged, it is likely that a court could not simultaneously agree to protect the fundamental right of families to rear their children as they please,¹⁵⁰ to deny the fundamental right of terminally ill patients to physician-assisted suicide,¹⁵¹ and to affirm the

145. Angellea, *supra* note 116, at 195–96.

146. Valerie S. Prater, *Confidentiality, Privacy, and Security of Health Information: Balancing Interests*, UNIV. ILL. CHI. (Dec. 8, 2014), <https://healthinformatics.uic.edu/resources/articles/confidentiality-privacy-and-security-of-health-information-balancing-interests/> [<https://perma.cc/LTG4-HZM4>]. Some have drawn a distinction in the health care context between “privacy” and “confidentiality,” identifying the latter as the more appropriate consideration in the context of personal health information. *See, e.g., id.* This is due to the lesser degree of privilege necessary to allow for the functional sharing of health information in furtherance of treatment. *Id.*

147. WORLD HEALTH ORG., EARLY DETECTION OF HIV IN INFANTS AND CHILDREN 1–2 (2007), http://www.who.int/hiv/paediatric/EarlydiagnostictestingforHIVVer_Final_May07.pdf [<https://perma.cc/5V34-TRVL>].

148. N.Y. COMP. CODES R. & REGS. tit. 10, § 69-1.5 (2018).

149. *See* *Vacco v. Quill*, 521 U.S. 793, 808–09 (1997).

150. *Pierce v. Soc’y of Sisters*, 268 U.S. 510, 534–35 (1925) (holding that children could not be required to attend public schools); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923) (discussing parents’ liberty to raise their children and control their education).

151. *Washington v. Glucksberg*, 521 U.S. 702, 728 (1997).

more sweeping and broadly defined right to privacy¹⁵² while still allowing the treatment mandate to exist. The Baby AIDS Bill draws a red line through some of the most deeply rooted substantive due process protections, creating a constitutionally offensive policy of treatment and giving rise to circumstances prone to civil liability under state-created danger.

In the immediate aftermath of the regulation, reports from HIV-positive mothers confirmed some of the fears that opponents of the Bill had voiced.¹⁵³ While Mayersohn continued to cast the Baby AIDS Bill as progressive protection of the health care rights of children, she denied, despite the language of the regulation implementing the law, that it was medication enforcement.¹⁵⁴ However, this proved to play out differently in the health care setting. One mother reported that she encountered doctor after doctor who threatened her with loss of custody if she refused treatment for her HIV-positive infant.¹⁵⁵ This mother also noted the fears another physician expressed about losing his license.¹⁵⁶ Caught between these two responses at a time when HIV treatment and its long-term effects were much less understood, treatment was at least implicitly mandatory, even if physicians managed to escape or evade a strict application of the regulation.

It is not a great legal leap to characterize HIV treatment much as the court characterized abortion in *Roe*: as a medical decision, the responsibility of which fundamentally rests with the physician.¹⁵⁷ The Court chose in *Roe* to refrain from interfering with health care decisions, and in doing so, protected the government from setting policy that would require additional government resources to properly facilitate.¹⁵⁸ But the law in this case removes the decisional component that would traditionally be associated with *in utero* or post-partum health care. The physician must test the infant, and if the infant is positive, the physician must provide or arrange for care.¹⁵⁹ In creating these requirements, the

152. *Poe v. Ullman*, 367 U.S. 497, 522 (1961).

153. Celia Farber, *AIDS: Words from the Front*, SPIN, Dec. 1996, at 127.

154. *Id.* at 128.

155. *Id.* at 162.

156. *Id.*

157. Hill, *supra* note 53 (quoting the majority opinion in *Roe v. Wade*).

158. *Roe v. Wade*, 410 U.S. 113, 153–54 (1973).

159. N.Y. COMP. CODES R. & REGS. tit. 10, § 69-1.5 (2018). The language of the regulation is somewhat unclear: “in the case of newborns who test positive for HIV antibodies” the “responsible physician shall . . . provide or arrange for health care, case management and other social services as needed for the newborn.” *Id.* This could suggest that the responsible physician is required to engage in some kind of active treatment. But the Bill goes on to require that the physician “refer the mother and newborn to an HIV specialized care center for provision of the services required.” *Id.*

New York legislature deviated from the typical approach of enacting such a change through the judiciary; instead, it made a duty of care a part of the state's public health law and abrogated the authority of the medical profession, which served as one of the primary compelling interests in rejecting the right to physician-assisted suicide in *Glucksberg*.¹⁶⁰ It is prudent for the legislature and judiciary to leave medical decisions between a doctor and a patient given the individualized nature of care plans. While population health is a critical component of ensuring better quality of life for individuals, many administrative and regulatory agencies¹⁶¹ are equipped to develop these policies. Accordingly, the courts and legislature serve only to check these executive measures. When the government avoids legislating medical care, it also steers clear of mandating treatment that could subject the government to liability under constitutional and tort causes of action.

Despite the lengthy history of contrary constitutional law and practical arguments, New York's requirement for testing and treatment still carries the force of law today. Facially, and even empirically, this Bill provides a social good in some sense.¹⁶² The universality of the testing requirement diminishes barriers to accessing diagnostic care, and in the years following the Bill, more than 230,000 infants were tested, resulting in the identification of nearly 1,000 infants with HIV.¹⁶³ Still, the Constitution is not framed to protect social goods, and even when it does so incidentally, the extent to which something is "good" is often more a matter of politics than morals.¹⁶⁴ From its genesis, just as the Baby AIDS Bill has been lauded as a public health and children's rights victory, it has been indicted as an affront to the women's health care rights secured in *Roe*.¹⁶⁵

But now that it has passed, what alternative is there? In one sense, to not test would be to deprive the child of a chance at an HIV-free life if the child had indeed contracted HIV *in utero*. This chance is only secured by interpreting the regulation's mandate as an affirmative requirement to test *and* treat, and as discussed, the treatment aspect is the most squarely

160. *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997).

161. See, e.g., *HHS Offices and Agencies*, COMMISSIONED CORPS U.S. PUB. HEALTH SERV. (Dec. 30, 2017), <https://www.usphs.gov/aboutus/agencies/hhs.aspx> [<https://perma.cc/RF6Y-GK2X>].

162. Abramson, *supra* note 126, at 337.

163. *Id.* Ten percent of these mothers did not know they were HIV-positive while pregnant, and seventy-seven were referred back to local health departments for follow-up care. *Id.* The testing requirement, strictly speaking, did inform a significant number of women of a major health issue that could have been fatal without treatment. *Id.*

164. Steven Strasnick, *Individual Rights and the Social Good: A Choice-Theoretic Analysis*, 10 HOFSTRA L. REV. 415, 416 (1982).

165. See Angellea, *supra* note 116, at 206–08.

at odds with the bulk of Supreme Court doctrine prohibiting the enforcement of life-sustaining treatment and protecting bodily autonomy. Yet, to test and not initiate treatment could mean sending a child home to die during the first year of life.¹⁶⁶ Case law is clear that a child, even one *in utero* at a certain point in gestation, has a fundamental interest in the right to life that is traditionally balanced against the mother's rights.¹⁶⁷ Therefore, the State's protection of the interest in the infant's right to life as articulated in *Roe* and refined in *Casey*¹⁶⁸ is only possible if the court exercises a degree of blindness to the holdings of *Glucksberg* and *Vacco*,¹⁶⁹ or else gives one of these interests precedence.

C. HIV Treatment as Danger Without Protection

The fact that a newborn can begin her life terminally ill is a tragedy of biology. Despite significant advances in medical science, some conditions present at birth remain incurable. Fortunately, HIV is generally manageable with a strict regimen of medication.¹⁷⁰ Nonetheless, a baby born with HIV and unable to receive treatment is essentially terminally ill. Under *Glucksberg*, *Cruzan*, and *Quill*, forcing a child to receive life-sustaining treatment is inapposite to the doctrine protecting individuals from harm at the hands of a state law.¹⁷¹

The most dangerous outcome of these policies is the newborn testing positive for HIV, being connected to care and administered antiretroviral drugs, and then being treated inconsistently over the course of her life. This is especially likely given systemic health care inequities that show a strong inverse correlation between income and access to care, and HIV prevalence.¹⁷² If treatment is interrupted, it has the potential to be less effective for the duration of the infant's life as the virus develops

166. See David Dunn, *Short-Term Risk of Disease Progression in HIV-1-Infected Children Receiving No Antiretroviral Therapy or Zidovudine Monotherapy: A Meta-Analysis*, 362 LANCET 1605, 1605 (2003).

167. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 846 (1992).

168. *Id.*

169. *Vacco v. Quill*, 521 U.S. 793, 809 (1997) (holding that laws prohibiting physician assisted suicide did not violate equal protection); see also *Washington v. Glucksberg*, 521 U.S. 702, 728 (1997) (declining to recognize a fundamental right to die).

170. *HIV Treatment: The Basics*, *supra* note 141.

171. See *Glucksberg*, 521 U.S. at 728; *Vacco*, 521 U.S. at 809; *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 280 (1990).

172. Anna Satcher Johnson et al., *Monitoring Selected National HIV Prevention and Care Objectives by Using HIV Surveillance Data: United States and 6 Dependent Areas*, 21 HIV SURVEILLANCE REP. 1, 8–10 (2014). African-Americans experience much higher rates of HIV and vertical transmission, but generally experience more access barriers to health care. *Id.* Thus, newborns in this community are more likely to be born with HIV, but less likely to be able to obtain treatment for it. See *id.*

resistance over time without being sufficiently repressed.¹⁷³ The action mandated by the statute can therefore be construed as state action that requires the infant to receive health care, which must be continuous, uninterrupted, and comprehensive, for the chronic issues associated with HIV.¹⁷⁴ Without this standard of care, it is possible that the statutory requirements—which already subject the infant to the battery found unlawful in *Glucksberg*—can deprive the infant of the chance of long-term successful viral repression. Short-term intervention will prolong the life of the child, but only continuous therapy will allow for a normal life.

One solution, then, is to characterize the treatment component as state-created danger that creates government liability under one of the tests recognized by a circuit court.¹⁷⁵ There are conceptual hurdles to framing medical treatment as harm, since the fundamental goal is to prolong life or improve the quality of remaining life. But this definition of health care assumes consent, and it does not necessarily anticipate the unique contours of illnesses such as HIV. In the case of vertically transmitted HIV, the lack of consent makes the absence of guaranteed care more problematic, since the child will be forced to maintain therapy—therapy the state may not provide—for successful viral repression.

Consent, ostensibly by the mother who has the power to make health care decisions for her child,¹⁷⁶ is not explicitly required in the Baby AIDS Bill, and the reading espoused by this Note shows that the duty is placed on the physician.¹⁷⁷ Without consent, health care transitions from a willful patient-physician relationship, where the patient is waiving certain rights (including constitutionally protected ones, like privacy), to an imposed treatment that may place the individual in danger. This lack of consent is essential to fully conceptualizing the harm. While it is well settled that minors generally are not afforded the right to make their own health care decisions, the New York Baby AIDS regulation makes no accommodation for the statutory power of consent afforded to mothers.¹⁷⁸

173. Olsen et al., *supra* note 16, at 102–03.

174. *HIV Treatment: The Basics*, *supra* note 141.

175. Chemerinsky, *supra* note 106, at 15–17.

176. Alireza Parasapoor, *Autonomy of Children and Adolescents in Consent to Treatment: Ethical, Jurisprudential, and Legal Considerations*, 24 *IRAN. J. PEDIATRICS* 241, 243 (2014). Globally, the age of majority differs for various social, cultural and religious reasons. *See id.* Nonetheless, physicians in all countries will encounter situations where they are asked to treat or faced with treating a child without parental consent. This is more difficult in the United States, where the circumstances under which a minor may unilaterally make health care decisions are extremely limited. *Id.*

177. N.Y. COMP. CODES R. & REGS. tit. 10, § 69-1.5 (2018) (“The *responsible physician* shall[,] . . . in the case of newborns who test positive for HIV antibodies[,] . . . provide or arrange for health care” (emphasis added)).

178. N.Y. PUB. HEALTH LAW § 2504 (McKinney 2017).

Both HIV-positive women and children—though practically benefiting from temporary access to care—suffer greatly in terms of the rights that are compromised by this legislation.

The circuit courts have provided various tests for assessing state-created dangers, which borrow in varying degrees from the *DeShaney* decision.¹⁷⁹ The cases have traditionally addressed physical, and often criminal, violence that the state fails to prevent.¹⁸⁰ However, the harm or danger in the case of the Baby AIDS Bill is no less threatening if the government is not also guaranteeing individuals lifelong care. *Hart v. City of Little Rock*¹⁸¹ offers one model for perceiving forced treatment without guaranteed care as a state-created danger, the application of which would first require an articulation of the harm.¹⁸² As seen in both the health care liberties and state protection contexts, it is often the narrowness of the framing that either assists in garnering recognition by the Supreme Court or in disposing of the right altogether.¹⁸³ Here, the liberty is narrow by nature, applying only to a small population of HIV-positive infants in New York State. The state creates danger by requiring physicians to treat HIV-positive infants without providing for and ensuring the continued availability of care and treatment, thus placing the infants at a greater risk of resistance to treatment.¹⁸⁴ The danger is that antiretroviral therapies will be less effective if the individual loses access to care as a condition of indigency or economic hardship or as a result of the inability of parents to provide care.

The Baby AIDS Bill falls squarely within the confines of a state-created danger as defined by the test described in *Hart*. First, the plaintiff

179. Chemerinsky, *supra* note 106, at 16–17. The current tests for state-created danger set a high bar for a cause of action. The plaintiff must often be able to show extreme recklessness or deliberate indifference. *Id.* The likelihood of a court ever finding deliberate indifference in a widespread public health policy would be politically pernicious, further underscoring why there is a history of refraining from judicial interference with the medical profession.

180. *See generally id.* (discussing some of the most recent cases in the Supreme Court and Federal Circuit Courts that have dealt with the issue of state-created danger, those most influential in shaping the doctrine involve physical violence and criminal offenses). This should not preclude the doctrine's application to the Baby AIDS Bill, since the harm created is still a type of battery.

181. 432 F.3d 801 (8th Cir. 2005).

182. *Id.* at 805.

183. *Understand Medical Aid in Dying*, COMPASSION & CHOICES (Dec. 30, 2017), <https://www.compassionandchoices.org/understand-medical-aid-in-dying/> [<https://perma.cc/RHK3-4X84>]. Seven states now have laws allowing medical aid-in-dying. *Id.* Advocacy organizations like Compassion and Choices distinguish between “medical aid in dying” and “assisted suicide.” *Id.*

184. *HIV Treatment: The Basics*, *supra* note 141.

must be a member of a precisely defined group.¹⁸⁵ The focus of the Baby AIDS Bill and implementing regulation applies only to the relatively small group of children who test positive for HIV at birth, and the harm is typically only present for those who continue to test positive after eighteen months to two years, since that generally indicates vertical transmission of the virus. Narrowness is sufficient. Second, the state conduct must be shown to put this group in “serious, immediate, and proximate harm.”¹⁸⁶ Antiretroviral therapy (ART) resistance is medically serious, and given that a failure to respond to treatment could be fatal in a year’s time, the harm is reasonably immediate in the health care context.¹⁸⁷ Additionally, treatment resistance can only be caused by intervention, which makes the post-natal treatment the only proximate harm. Third, the risk must be “obvious or known” to the government.¹⁸⁸ It is widely known in the medical community that discontinuous care can result in drug resistance to ART.¹⁸⁹ Fourth, *Hart* requires that the act was done with a conscious disregard of a high degree of risk—a particularly high standard in civil tort suits.¹⁹⁰ Other circuits have similarly applied a deliberate indifference standard.¹⁹¹ Either would appear challenging in the case of the Baby AIDS Bill to establish in the legal context, since the Bill is quite the opposite of reckless disregard in its final intent. However, there is a high degree of risk of developing resistance when the infant receiving care is neither responsible for his own treatment nor able to control the continuity of care. Without guaranteeing access to care to the extent that it may, the government must question whether it should be requiring treatment at all.¹⁹² Thus, the reckless disregard of the potential consequences of this regulation is clear. Finally, *Hart* looks at whether the totality of the act “shocks the conscience.”¹⁹³ This final factor invokes the numerous transgressions of constitutional protections that result from the Baby AIDS Bill—the invasion of privacy, the force of treatment, and

185. *Hart*, 432 F.3d at 805; see also *HIV Among Pregnant Women, Children, and Infants*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/hiv/group/gender/pregnant-women/index.html> [<https://perma.cc/W6ZE-7369>] (last updated Mar. 21, 2018).

186. *Hart*, 432 F.3d at 805.

187. Olsen et al., *supra* note 16.

188. *Hart*, 432 F.3d at 805.

189. *HIV Treatment: The Basics*, *supra* note 141.

190. *Hart*, 432 F.3d at 805.

191. See, e.g., *Kennedy v. City of Ridgefield*, 439 F.3d 1055, 1062 (9th Cir. 2006).

192. Chemerinsky, *supra* note 85, at 1503. There is a critical distinction, particularly in health care cases, between what is an ethical mandate within the medical profession and what the government can subsume within constitutional limits. Chemerinsky characterizes medical aid-in-dying, for example, as “controversial, but as a constitutional matter, not difficult.” *Id.* This same characterization is fitting for the Baby AIDS Bill, which likely would not have withstood the constitutional analysis it should have been subjected to at its origination.

193. *Hart*, 432 F.3d at 805.

the blurring of important functional lines between the legislature, the court, and the medical profession. The disruption of defined fundamental rights may not evoke the same sort of horror that the violence against Joshua DeShaney did, but the fact that law like this can exist without some sort of continuing care provision for the individuals affected is necessary mitigation for the violation of liberty.

There are more stringent tests for the state-created danger, but most conceptually seek to determine whether the government has (usually recklessly) placed an individual in a worse situation than the individual was in prior to the government action.¹⁹⁴ Colloquially, the courts have adopted the snake-pit metaphor from a famously colorful description by Judge Richard Posner out of the Seventh Circuit to describe the idea of placing someone in danger.¹⁹⁵ Commonly, courts are trying to arrive at whether the state put the individual at risk of “private violence” without affording some protection.¹⁹⁶

It is an uphill battle to define the contours of the harm that can result from the Baby AIDS Bill. Doing so requires looking past the facial benefit of the Bill, which seeks to prevent HIV infection and circumvent any early fatal complications. It also requires that legislatures and health departments stop conflating the “need to protect and treat” from an ethical compulsion to do so.¹⁹⁷ But this risk is a tradeoff, because the harm of resistance to treatment merely comes later if the child is not guaranteed consistent access to HIV care. Simply put, mandating treatment for HIV without providing access to care creates harm without offering protection—avoiding one snake pit in favor of another. For this narrow population of babies born with HIV, in order to prevent a mere deferral of harm, it would be necessary for there to be government-provided health care that is neither subject to gaps in coverage, nor susceptible to disappearance in the face of financial fluctuations, and is easily administered despite race and class disparities.

194. Chemerinksy, *supra* note 106, at 15–18. Every circuit has some version of the test, and the tests are primarily distinguished by some special requirement, such as shocking the conscience or being part of a precise class. *Id.* New York, as a state in the Second Circuit, would actually be held to a more relaxed standard, where an individual can proceed on a § 1983 action where it is either in a special relationship with the government, *or* where the state created the danger. *Id.* at 18. Consider that in the case of the Baby AIDS Bill, either is possible, since children born into the foster care system may have the status of a ward. *See* *Pena v. Deprisco*, 432 F.3d 98, 109 (2nd Cir. 2005).

195. *Bowers v. DeVito*, 686 F.2d 616, 618 (7th Cir. 1982) (“If the state puts a man in a position of danger from private persons and then fails to protect him, it will not be heard to say that its role was merely passive; it is as much an active tortfeasor as if it had thrown him into a snake pit.”).

196. *Pena*, 432 F.3d at 108–09.

197. Bryce, *supra* note 116.

CONCLUSION: IMPLICATIONS OF THE BABY AIDS BILL FOR NATIONAL HEALTH POLICY

Despite having existed for over two decades, mandatory testing for HIV, especially without consent, has not caught fire in state public health policies. When President Bill Clinton reauthorized the Ryan White CARE Act, the Act included requirements that states demonstrate that ninety-five percent of pregnant women were tested for HIV or that there was otherwise a fifty percent reduction in infants born with HIV.¹⁹⁸ Policy analysts speculate that the millions of dollars in funding tied to this requirement were integral in encouraging new public health practices to monitor or prevent perinatal transmission of HIV, particularly in New York.¹⁹⁹ Why, then, does only one other bill in the United States bear any resemblance to New York's in its mandate for unblind mandatory testing?²⁰⁰ The answer likely lies in the relatively low benefit and the considerably high risk of creating unsustainable and unconstitutional public health policies.

As a public health practice, these bills do little empirically to move the needle in reducing the transmission of HIV because the population is so small and the first few years of life so difficult.²⁰¹ Voluntary testing and treatment have long been regarded as the preferred means of monitoring HIV status in any situation, let alone widespread maternal-focused public health policies.²⁰² In the aggregate, the absence of a widespread adoption of mandatory unblind testing does not appear to have been dispositive in abating the prevalence of vertical HIV transmission: from 2008 to 2013, the rate of perinatal HIV transmission dropped from 3.6 to 1.8 per 100,000 live births.²⁰³ Education and voluntary testing are prevailing.

Without a guaranteed health care provision, the Baby AIDS Bill epitomizes incomplete and dangerous legislation that reaches an attainable goal by the *most* restrictive means.²⁰⁴ New York preserves a

198. Nicholson, *supra* note 116, at 175–76.

199. Abramson, *supra* note 126, at 332–33.

200. Bryce, *supra* note 116. Connecticut is the only other state that mandates testing of newborns without the mother's consent. *Id.*

201. Nicholson, *supra* note 116, at 182.

202. See Peter H. Berge, *Setting Limits on Involuntary HIV Antibody Testing under Rule 35 and State Independent Medical Examination Statutes*, 44 FLA. L. REV. 767, 798–99 (1992). Just a decade into the epidemic, states were already keeping HIV testing separate from other involuntary testing requirements mandated by medical examination statutes related to tort suits. *Id.* This was reflective of an overwhelming consensus in the medical community that voluntary testing was more workable and effective. *Id.* at 793.

203. Johnson et al., *supra* note 172, at 47 tbl.8(b).

204. Noah Marks, *Least Restrictive Means: Burwell v. Hobby Lobby*, 9 HARV. L. & POL'Y REV. ONLINE 19, 21 (2015). When the Supreme Court applies a “strict scrutiny” standard in

major vulnerability in its public health laws and regulations by allowing this Bill to exist in its present form. The Baby AIDS Bill sets precedent for involuntary testing and treatment, which gives the public health community power over some of the most protected and sacred decisions possible in our society.²⁰⁵ The legislature and judiciary should avoid the furtherance and enforcement of policies like the Baby AIDS Bill without the necessary constitutional support in place first. A public health practice that so wantonly affects individuals' future health without any provision for the necessity of care it creates is fraught with danger. The conflicts between this policy and clearly defined constitutional rights regarding active treatment, bodily autonomy, and fundamental privacy compound this danger. Until the government provides comprehensive health care for HIV, the harm the Baby AIDS Bill has created remains unmitigated.

assessing violation of fundamental rights, it generally looks at whether the challenged government regulation is the least restrictive means of achieving the aim of the regulation, which seeks to minimize government intrusion. *Id.* The Baby AIDS Bill, as demonstrated by the success of other states with less restrictive requirements, does not meet this standard.

205. Nicholson, *supra* note 116, at 184–85.