
CRIMINAL ISSUES

INTRODUCTION

One of the most significant legal developments to affect the HIV/AIDS community since the publication of the 1995 edition of this manual has been the threat of criminal prosecution for behavior directly or indirectly related to one's HIV/AIDS status. This chapter specifically addresses relatively recent laws relating to medical marijuana, intentional transmission of HIV/AIDS, and viatical settlements. Proposition 215, also known as the Compassionate Use Act, was passed by a majority of California voters in 1996, but has resulted in a great deal of confusion and uncertainty as to what remains legal and illegal use of medical marijuana. More recently, in 1998, California enacted a law that makes intentional transmission of HIV/AIDS a felony. However, only in the last few years have people actually been prosecuted under this law, and at this point the success of such prosecutions remains unclear. In the early 1990's, life insurance holders who had HIV/AIDS commonly engaged in the practice of selling their policy to a viatical company in order to cover medical expenses. Many even crossed the line of legality, applying for numerous life insurance policies, and then selling them almost immediately upon approval. In 1996, viatical issues for the HIV/AIDS community suddenly erupted into highly complex legal issues due to drastic improvements in protease inhibitors and other medications resulting in a far longer life expectancy than that of the early 1990's.

Although ALRP attorneys do not typically provide legal advice to criminal defendants, it is important for attorneys and clients to understand the current state of the law in these areas. Nevertheless, after an initial consultation, clients should be referred to the office of the San Francisco Public Defender at (415) 553-1671.

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MEDICAL MARIJUANA AND HIV/AIDS

I. Introduction¹

Ever since California voters approved a 1996 ballot measure legalizing some medicinal uses of marijuana, the state has been locked in a legal and cultural battle with the federal government. Federal agents have razed farms where medicinal marijuana is grown, closed cooperatives where it is distributed, and threatened to revoke the prescription license of doctors who discussed it with their patients. However, advocates of medical marijuana recently rejoiced at a major legal victory that effectively allows doctors to recommend the drug to patients. Nevertheless, the federal government vows to continue its war against medical marijuana users, and it is therefore important that our clients understand the current state of law. This becomes challenging as new legal developments appear frequently. The best source of updated information about these developments can be found on the Drug Policy Alliance's website at <http://www.drugpolicy.org>.

This chapter discusses the medical uses for marijuana, California and federal law regarding medical marijuana, complications related to public benefits, housing, family law and employment, and the operation of local cannabis clubs.

Volunteer attorneys should be able to explain to a client how s/he should go about obtaining medical marijuana, as well as the distinctions between the federal and state laws. Please note that despite the ominous threat of federal prosecution, typical users of medical marijuana have not been targeted. In other words, so long as clients have a medical cannabis ID card, they are safe to use and even grow marijuana for personal medicinal purposes. However, if a client calls to ask for help regarding a criminal prosecution, s/he should be referred to the local public defender's office or to one of the attorneys listed on National Organization for the Reform of Marijuana Law's (NORML) website at: <http://www.canorml.org>.

II. Medical Uses of Marijuana for Symptoms Associated With HIV

Studies and anecdotal evidence indicate that the medical use of cannabis can alleviate symptoms associated with HIV, and much of the medical community supports medicinal usage. The Institute of Medicine published a federally-funded study on the scientific basis of medical marijuana in 1999. That report concluded:

The accumulated data suggest a variety of indications, particularly for pain relief, antiemesis, and appetite stimulation. For patients, such as those with cancer or undergoing chemotherapy, who suffer simultaneously from severe pain, nausea, and appetite loss, cannabinoid drugs might thus offer broad-spectrum relief not found in any other single medication.²

Marinol (dronabinol) is a synthetic, orally-ingested drug that contains THC, one of the chief psychoactive agents in marijuana. It has been approved for treating anorexia

¹ The Medical Marijuana and HIV/AIDS section was written by Sheila Hall, Esq.; Skyla Olds, Law Clerk; Gail Silverstein, Esq. of the East Bay Community Law Center.

² *Institute of Medicine, National Academy of Sciences, Marijuana as Medicine: Assessing the Science Base (1999).*

in people with HIV-related wasting syndrome. Unfortunately, Marinol has proven largely ineffective for many patients; the pharmaceutical contains only one of the more than four hundred active ingredients in marijuana and its effects often take hours to manifest (as opposed to seconds for inhaled marijuana). Although there is a concern that the inhalation of marijuana may cause additional health problems, Marinol does not provide an appropriate alternative in every circumstance.

There is extensive literature documenting the possibilities, advantages and concerns associated with medical use of cannabis for HIV patients. Studies and research, as well as affidavits of medical doctors attesting to their experience with the recommendation of medical marijuana, are available on the Drug Policy Alliance's website for litigators and can be viewed at:

<http://www.drugpolicy.org/marijuana/medical/challenges/litigators/medical/research/>.

Evidence attesting to the benefits of medical marijuana and the subsequent support of the medical community, encouraged several states to pursue initiatives decriminalizing medical marijuana.³

III. California Medical Marijuana Law: Compassionate Use Act

In California possession of cannabis is a misdemeanor, punishable by imprisonment in the county jail for up to one year and by a fine of up to \$500.⁴ Unauthorized cultivation of any marijuana is punishable by imprisonment in state prison.⁵

In 1996, California voters passed Proposition 215 to decriminalize the medical use of marijuana. Known as the Compassionate Use Act, the relevant language of the code states:

Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient's primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician.⁶

Although this decriminalizes medical marijuana use when recommended by a physician, it cannot protect those patients from federal laws or other state laws if a client uses medical marijuana outside of California. Current federal law and the conflict between the state and federal law are detailed in a later portion of this chapter.

The Compassionate Use Act explicitly contemplates the medical use of marijuana for the treatment of AIDS. The Compassionate Use Act begins with an articulation of intent. It declares the purpose to be:

To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use deemed

³ Since 1996, nine states have enacted such laws: California, Alaska, Arizona, Colorado, Hawaii, Maine, Nevada, Oregon, and Washington. See Cal; Alaska Stat. Ann. 11.71.090, 17.37.010 to 17.37.080 (2000); Colo. Const., Art. XVIII, 14; Haw. Rev. Stat. 329121 to 329128 (Supp. 2000); Me. Rev. Stat. Ann., Tit. 22, 2383B(5) (2000); Nev. Const., Art. 4, 38; Ore. Rev. Stat. 475.300 to 475.346 (1999); Wash. Rev. Code 69.51A.005 to 69.51A.902 (1997 and Supp. 2000/2001). For the purpose of this section, we will only explore in detail the California statute.

⁴ CA HLTH & S §11357.

⁵ CA HLTH & S §11358.

⁶ CA HLTH & S § 11362.5(d).

appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief.⁷

IV. Protection Afforded by the California Medical Marijuana Law

Although the Compassionate Use Act declares that the normal criminal codes do not apply to patients who use medical marijuana on the recommendation of a physician, it does not provide complete immunity for such patients. In 2002, the California Supreme Court ruled that a patient can still be arrested and charged for possession and cultivation, but the Compassionate Use Act entitles partial immunity. The Court directed that in addition to providing an affirmative defense during trial, individuals could have the prosecution set aside before trial if they show that the police did not have reasonable or probable cause to believe they were not in compliance with the Compassionate Use Act.⁸ Thus, the law can protect a patient from conviction, and in some instances prosecution, but the risk of arrest remains. A patient may also be entitled to the return of any medical marijuana seized by the police.

For an online brief bank of model motions and briefs relating to litigating and dismissing these cases, see:
<http://www.drugpolicy.org/marijuana/medical/challenges/litigators/legal/briefbank/>.

In addition, California Senate Bill 420, signed by then-Governor Davis, went into effect as law on January 1, 2004. SB 420 establishes a voluntary identification card system to protect patients and caregivers from arrest throughout the state. The card, which is modeled on the San Francisco ID system in order to protect patient privacy, would protect against arrest for not only possession and cultivation, but also transportation and other related charges for persons adhering to guidelines of 1/2 pound of marijuana and up to 6 mature or 12 immature plants.

Supporters of SB 420 argue that the guidelines are not a ceiling on what patients can have, but rather a floor beneath which they will be protected from arrest. They point out that SB 420 does not and cannot limit the amount of medicine patients may legally possess or grow, since Prop. 215 gives them the right to as much medicine as necessary for their personal medical use. Under SB 420, patients with state cards who adhered to the guidelines will be protected from arrest. On the other hand, patients who exceeded the guidelines will be subject to arrest, but shall still retain their full Prop. 215 rights in court. As additional protections, SB 420 specifies that patients can exceed the guidelines if their physician says that is necessary and permits local jurisdictions to enact more liberal guidelines if they wish.

⁷ § 11362.5(b)(1)(A).

⁸ *People v. Mower*, 28 Cal.4th 457, 464 (2002).

Although medical marijuana activists were sharply divided on SB 420, the bill was widely viewed as a test of support for medical marijuana by the state legislature.

Finally, in November 2002, San Francisco voters approved Proposition S, which called on city officials to consider helping with the distribution of medical marijuana. The San Francisco Board of Supervisors is still meeting to determine whether they will create a municipal medical marijuana garden, in defiance of federal law, or whether a less confrontational and more low-key approach will be taken.

V. Status of Medical Marijuana Under Federal Law

Any use, possession, or cultivation of cannabis is a crime under federal law. Marijuana is considered a Schedule I drug under the Federal Controlled Substance Act⁹ and penalties are controlled by complicated federal sentencing guidelines.¹⁰ A Schedule I classification means that a drug has a high potential for abuse and no accepted medical use.¹¹

A patient in compliance with California's law will be afforded no protection under federal law. There have been several occasions under which federal law enforcement has come in without the cooperation of state law enforcement, and raided and arrested individuals and buyers. The federal prosecution of Ed Rosenthal in the District Court in San Francisco in 2002 garnered a lot of attention and showed that an individual cannot even introduce evidence into a federal case to demonstrate that the marijuana was grown with medical purposes in compliance with state law.

The U.S. Supreme Court has ruled that cannabis buyers' clubs cannot use the medical necessity defense for violating federal law by dispensing marijuana.¹² The narrow ruling, which upheld a Ninth Circuit Court of Appeals decision in October 2002, did not comment on the legitimacy of the state law and did not specifically address whether an individual could use that defense. However, on October 14, 2003, the Supreme Court denied the Bush administration's request for certiorari on the issue of whether the federal government can threaten or punish doctors for discussing and recommending medical marijuana to patients.¹³ This decision stands for the proposition that government may not prohibit doctors from speaking freely with patients about medical marijuana.

If federal and state law *directly* conflict, federal law is supreme. However, courts have not considered the question of whether state medical marijuana laws directly conflict with the federal treatment of marijuana under the Controlled Substance Act, and the general belief is that a facial challenge to these laws by the federal government would not succeed since they do not directly conflict.¹⁴

⁹ 21 U.S.C. § 811.

¹⁰ U.S. Drug Enforcement Agency, *Drug Scheduling* (<http://www.usdoj.gov/dea/pubs/scheduling.html>).

¹¹ 21 U.S.C. § 812 (1/22/02).

¹² *U.S. v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483 (2001).

¹³ *Conant v. Walters*, 309 F.3d 629 (2002).

¹⁴ Judy Appel & Daniel Abrahamson, *Medical Marijuana Law and Legislation: The Role of State Law Enforcement* (viewed at <http://www.safeaccessnow.org/article.php?id=183>).

Although federal prosecutions have occurred, they appear to be focused on high profile cases. Americans for Safe Access report that in 2002, thirty people who were operating legally under the Compassionate Use Act were targeted for federal law enforcement actions.¹⁵ Although it may be unlikely that the federal government will raid a patient who is not a public figure or otherwise the focus of media attention, there is always the risk of federal prosecution.

VI. Complication of Medical Marijuana Related to Other Legal Issues

In addition to the risks of criminal prosecution for use of an illegal substance – both at the federal level and the state level if the patient doesn’t qualify under the Compassionate Use Act – using marijuana to treat HIV can have serious legal status implication for clients. Below are a few of the areas where medical marijuana use may create significant obstacles.

A. Public Benefits

Many public benefits can be reduced, revoked, or denied based on a current or previous drug conviction. Federally funded welfare through Temporary Assistance to Needy Families (TANF) and food stamps includes a ban for drug felonies that states can opt out of,¹⁶ but California has so far failed to do so. How medical marijuana is dealt with under general felony and drug bans is unclear, but the Compassionate Use Act does not provide any official protection. Clients who use medical marijuana risk exposing themselves to whatever penalties accompany drug use, although if the penalties are attached to a felony conviction, the California Compassionate Use Act should protect them from any additional convictions if they are in compliance with the law.

Social Security Administration’s (SSA) regulations deny federal disability benefits to claimants if their drug use “materially” contributes to the medical condition(s) that the claimant alleges is disabling.¹⁷ SSA policy states that drug use is material to the disability determination if the individual would not be found disabled if the use of drugs or alcohol were to stop.¹⁸ If the SSA knows your client uses marijuana or has a positive drug test on her record, it may object on materiality grounds to a finding of disability. Although there is no policy within SSA on this issue, it is recommended that you obtain a letter from the patient’s doctor that explains that the patient is using marijuana as a form of medical treatment and that it does not contribute to the disability.

B. Public Housing

Federally subsidizing housing programs have severe policies regarding drug use and do not make exceptions for medical marijuana. The Department of Housing and Urban Development (HUD), has a one-strike policy where:

¹⁵ Americans for Safe Access, *Medical Marijuana Legal Manual*. For more information about this manual, please see www.safeaccessnow.org

¹⁶ 21 U.S.C.S. § 862(a).

¹⁷ Pub. L. No. 104-121, § 105(a)(1), (b) (1), 110 Stat. 847, 852-53 (1996).

¹⁸ Program Operations Manual System (POMS) DI 90070.050A. See 42 U.S.C. § 423(d)(2)(C), 1382c(a)(3)(J).

any drug-related criminal activity on or off such premises, engaged in by a public housing tenant, any member of the tenant's household, or any guest or other person under the tenant's control, shall be cause for termination of tenancy.¹⁹

This policy was upheld by the U.S. Supreme Court in *Department of Housing and Urban Development v. Rucker*, 535 US 125 (2002).

The Office of National Drug Control Program (ONDCP) stated that HUD will continue to enforce its one-strike policy and not make exceptions for medical use following the passage of California's Compassionate Use Act.²⁰ Although this is the federal policy, local Housing Authorities may be more receptive to arguments based on medical necessity and reasonable accommodations. There is no indication as to how the local housing authorities in this area view medical marijuana claims.

The best recommendation for clients is to keep their medical use a private matter in the housing context, especially if they are public housing tenants. If a client's medical marijuana use comes to the attention of a landlord or housing authority, the same steps of requesting reasonable accommodations of disability and providing verification from the doctor explaining why medical marijuana is appropriate are recommended.

C. Family Law

A positive drug test for medical marijuana may be enough to initiate investigations for child neglect. Again, although there is no set policy on how to address this, the first step should always be to collect information to educate the decision maker. There are publications that conclude that evidence of drug use should not be a proxy for child neglect or abuse. The American Bar Association has concluded that:

many people in our society suffer from drug or alcohol dependence yet remain fit to care for a child. An alcohol or drug dependent parent becomes unfit only if the dependency results in mistreatment of the child, or in a failure to provide the ordinary care required for all children.²¹

The concept that drug use *per se* does not indicate abuse is further bolstered by the medical acceptance of marijuana as prescribed treatment for HIV. Letters from the client's doctor explaining why this is a recommended medical treatment, supported by evidence related to treating HIV and AIDS symptoms, will likely be important in refuting any involvement in child protection services.

D. Employment

California employers can require that potential employees be drug-tested before being hired²² but can only drug test current employees under limited circumstances (including reasonable suspicion of drug use affecting job performance or if the job's

¹⁹ 42 U.S.C. § 1437(d)(1)(6), 24 C.F.R. 982.553.

²⁰ Statement Released by Barry McCaffrey, Director of ONDCP, *The Administration's Response to the Passage of California Proposition 215 and Arizona Proposition 200*, (Dec.30, 1996) (viewed at: <http://www.noveltynet.org/content/paranormal/www.parascope.com/articles/0897/cannabisdoc.htm>).

²¹ American Bar Association, Foster Care Project, National Legal Resource Center for Child Advocacy and Protection, *Foster Children in the Courts*, 206 (1983).

²² *Wilkinson v. Times Mirror Corp.*, 215 Cal. App. 3d 1034, 1047 (1989).

nature is particularly sensitive to drug use).²³ The Drug Free Workplace Act requires that recipients of federal grants and contracts have policies prohibiting illegal drug use and include medical use of marijuana within the scope of prohibited drugs.²⁴ After the passage of California's Compassionate Use Act, the ONDCP indicated the Administration's intention to increase compliance with the Drug Free Workplace Act and focus on states with medical marijuana laws.²⁵

According to an advisory by ONDCP, the Department of Transportation (DOT) has issued a formal advisory to the transportation industry that safety-sensitive transportation workers who test positive under the federally-required drug testing program may not under any circumstance use state law as a legitimate medical explanation for the presence of prohibited drugs. DOT is encouraging private employers to follow its example.²⁶

In fact, Department of Transportation regulations instruct laboratory workers who administer drug tests that they must not verify a negative test result based on information that a physician recommended that the employee use a drug listed in Schedule I of the Controlled Substances Act. (e.g., under a state law that purports to authorize such recommendations, such as the "medical marijuana" laws that some states have adopted).²⁷

California law does not protect workers whose medical use of marijuana has resulted in positive drug tests. How employees address this issue will vary depending on their relationship with their employer. If your clients have reason to trust their employers, providing them with a letter from their doctor explaining the medicinal purposes before submitting to a drug test may help address the issue. Employees should be aware that they can probably be fired for using medical marijuana. The American With Disabilities Act (ADA) does not protect an employee's illegal current use of drugs.²⁸ An employee could attempt to request "reasonable accommodations" under the Californian Fair Employment and Housing Act (FEHA) but acceptance of such a request would be highly dependent on how receptive the individual employer is and presents significant risks.²⁹

VII. Cannabis Clubs in the Bay Area

Despite a DEA crackdown on various Bay Area cannabis clubs in early 2002, the clubs nevertheless continue to operate. A list of these clubs can be found on NORML's website. Indeed, new clubs appear to be opening on a regular basis despite the fact that

²³ *Ronald Smith v. Fresno Irrigation Dist.*, 84 Cal. Rptr. 2d 775, 99 C.D.O.S. 3641, 3643 (1999). See also *Hill v. National Collegiate Athletic Association*, 7 Cal. 4th 1, 56-57, 26 Cal. Rptr. 2d 834, 865 P. 2d 633 (1994).

²⁴ 41 U.S.C. 701(a).

²⁵ Statement Released by Barry McCaffrey, Director of ONDCP, *The Administration's Response to the Passage of California Proposition 215 and Arizona Proposition 200*, (Dec.30, 1996) (viewed at: <http://www.novelty.net/content/paranormal/www.parascope.com/articles/0897/cannabisdoc.htm>).

²⁶ *Id.*

²⁷ Federal Motor Carrier Safety Administration Regulations § 40.151(e), (viewed at <http://www.fmcsa.dot.gov/rulesregs/fmcsr/regs/40.151.htm>).

²⁸ 42 U.S.C §12114(a).

²⁹ See Legal Aid Society of San Francisco, Employment Law Center, *HIV & Your Workplace Rights, Drug Use and Testing*.

the new DEA administrator Karen Tandy has indicated that raids against California compassion clubs will continue.

The clubs, sanctioned by the cities in which they are located, continue to operate as they always have. In San Francisco, for example, people with serious illnesses such as HIV/AIDS should first get a physician's recommendation for medical marijuana, preferably from their regular doctor. A list of doctors willing to issue such referrals can be found on NORML's website.

Patients can then take the physician's recommendation to the San Francisco Dept. of Public Health (phone: 415-554-2890; located at 101 Grove St. at Polk & Grove across from City Hall) and receive a medical cannabis ID card. Registration with the city may cost medical users a modest fee. Once registered, patients simply present their ID cards to any of the dozens of Bay Area compassion clubs (some of which charge a fee for membership), where they may purchase their medicine. In Oakland, the Cannabis Buyers Club issues the ID cards (as opposed to the Oakland Dept. of Public Health), but does not act as a dispensary.

INTENTIONAL TRANSMISSION OF HIV

By Helen Tsao, Law Clerk, AIDS Legal Services, Law Foundation of Silicon Valley

HIV/AIDS Statutes

In 1998, California passed a law criminalizing the intentional transmission of HIV by those persons affected with the virus. “Any person who exposes another to HIV by engaging in unprotected sexual activity when the infected person knows at the time of the unprotected sex that he or she is infected with HIV, has not disclosed his or her HIV-positive status, and acts with the specific intent to infect the other person with HIV, is guilty of a felony punishable by imprisonment in the state prison for three, five, or eight years. Evidence that the person had knowledge of his or her HIV-positive status, without additional evidence, shall not be sufficient to prove specific intent.” Cal. Health & Safety § 120291(a).

“Sexual activity” includes vaginal or anal intercourse but does not include oral-genital sexual contact. Cal. Health & Safety § 120291(b)(1). “Unprotected sexual activity” refers to sexual activity without the use of a condom. Cal. Health & Safety § 120291(b)(2). Therefore, if a person uses a condom during sexual activity, he or she cannot be convicted under the statute.

This statute has rarely been used, likely because the specific intent standard is a difficult burden to meet. Under the statute, merely reckless behavior that creates a risk of infection will not rise to the level of a punishable offense. Instead, the prosecution must show that the person was deliberately trying to infect the other person with HIV.

HIV/AIDS Cases

California has five laws relating to HIV-specific crimes. However, prosecution is rare, and thus far only two California courts have heard a case under the intentional transmission statute. In 2002, San Francisco County Superior Court entered a \$5 million default judgment against former San Francisco Health Commissioner, Ronald G. Hill, in a fraud and negligence action. Mr. Hill’s former partner, Thomas Lister, alleged that he became HIV positive after engaging in unprotected sex with Mr. Hill, based on his intentionally deceptive assertions that he was HIV negative. *Lister v. Hill et al.*, No. 318443, default judgment entered (Cal. Super. Ct., San Francisco County, Feb. 22, 2002).

Mr. Lister said he trusted Mr. Hill and engaged in unprotected sex with him, since he “thought that anyone who is a health commissioner, especially in this city, wouldn’t lie about something like that.” Renee Koury, *Ex-S.F. Man Charged with Spreading AIDS Virus*, San Jose Mercury News, October 27, 2003, at 1B. It was not until several months into their relationship that Mr. Lister discovered one of Mr. Hill’s medical records, which indicated he had AIDS. Mr. Lister claimed that had he known about Mr. Hill’s status, he would not have had unprotected sex with him.

Mr. Hill was indicted by a criminal grand jury in September 2003 on criminal charges of intentionally infecting Mr. Lister and a second man with HIV. Mr. Hill went to trial on November 14, 2003.

The judge threw out the case because she thought the prosecution failed to meet the burden of specific intent that was necessary under the statute. This holding suggests that lying about one’s status is not enough to satisfy specific intent; rather, actual intent to infect is required.

In addition, in what could also become a historical local case, the San Mateo District Attorney's Office recently charged San Francisco resident Marty Tagle, a 36-year-old statutory rape suspect, with exposing a 16-year-old boy to HIV.³⁰ If convicted, Tagle could face an additional three years for exposing the boy to the virus, based on a little known statute never used before locally. The boy, who met Tagle on a telephone chat line, was reportedly unaware of Tagle's HIV-positive status.

In this case, whether the youth was aware that Tagle had tested positive for the virus is irrelevant. Generally the prosecution must prove intent to infect, but bears no such burden in cases connected to sex crimes. Under California Penal Code sec. 12022.85, any adult who is aware of being HIV-positive and who commits rape, or engages in oral copulation or unlawful intercourse with a person under the age of 18 could receive a three-year sentence enhancement for each offense. Prosecutors in Tagle's case do not believe Tagle intended to infect the boy with HIV. However, under the law, intention does not matter.

Comparison with Other States

Twenty-four other states also have statutes that make it a criminal offense for an HIV-infected person to engage in behavior that results in the transmission of HIV.³¹ However, many of these statutes have much weaker intent requirements. Such laws may make it a crime for those who know they have HIV or AIDS to engage in unprotected sex without disclosing their status to their partner. Thus, conduct that merely exposes another to HIV may be punished.

For example, Illinois makes it a Class 2 felony when a person, knowing he or she is infected with HIV, "engages in intimate contact with another" or "transfers... blood, tissue, semen, organs, or other potentially infectious body fluids...to another." 720 Ill. Comp. Stat. Ann. 5/12-16.2(a)(1), (2).

The statute is fraught with problems, because it does not define whether actual knowledge is required, such as knowledge of a positive test result, or just constructive knowledge, such as having symptoms. Christina M. Shriver, Article, *State Approaches to Criminalizing the Exposure of HIV: Problems in Statutory Construction, Constitutionality and Implications*, 21 N. Ill. U.L. Rev. 319, 332 (2001). Also, the statute talks about the transfer of "potentially infectious body fluids," which includes saliva and tears, since they contain the virus. However, these types of fluids pose no risk of transmission of the virus.

Louisiana's HIV exposure statute is even more problematic because it punishes those who intentionally expose another to the virus through sexual contact or by any other "means or contact," which includes "spitting, biting, stabbing with an AIDS-contaminated object, or throwing of blood or other bodily substances." La. Rev. Stat. Ann. § 14:43.5(D)(1) (West 1997). It also does not define what it means to "intentionally expose another."

These are a few examples of the HIV transmission statutes in other states. In comparison, the prosecution's burden is greater under the California statute, since it

³⁰ Tagle was arrested on November 18, 2003. Source: Dwana Bain and Sabrina Crawford, *Tough Sentence Sought in HIV Teen Rape Case*, San Francisco Examiner, January 9, 2004, at 7.

³¹ This includes exposure or transmission of HIV through sexual intercourse, spitting, or blood donation.

requires a much higher threshold of intent. The California statute is also much more limited as to the kind of conduct that is punishable.

VIATICAL ISSUES³²

In San Francisco during the late 1980's, AIDS struck like a cyclone, roaring through the gay male community, leaving devastation and panic in its wake. During a time when there was no effective treatment for AIDS, the disease advanced quickly and almost always ended in death. It is commonly reported that the most expensive part of a terminally ill patient's medical care is the end-of-life treatment in the weeks or months immediately preceding death. Because of the magnitude of the disability, people with AIDS were unable to work, resulting in financial ruin for many. This was before there were comprehensive social services to support the HIV/AIDS community. Most of today's AIDS service organizations that provide food, medicine, housing, and counseling were in their infancy or had not yet been created.

Without income or the support of social service agencies, many people with AIDS couldn't afford their skyrocketing expenses. They needed money quickly to pay for medicines, hospice care, etc. The free market responded with a proposal: "Give me your \$100,000 life insurance policy, and I will give you \$75,000 today." This was a very tempting offer for gay men with life insurance policies. Most did not have children or a stay-at-home spouse who would be financially dependent on the insurance proceeds after they died. It was a tempting business investment for the purchasers of the policy since the insured was terminally ill and they were assured a return on their investment in a matter of months. And so began the AIDS viatical explosion in the early 1990's.

A life insurance viatication occurs when a viatical company purchases the beneficiary and/or ownership rights to a life insurance policy by paying the insured (viator) a lump sum of money determined by the face value of the policy, the monthly premium payments, and the insured's life expectancy. Viators closest to death received the highest payouts. Those in earlier stages of AIDS received less. The payouts tended to be substantial because it was understood that people with AIDS had very short life expectancies. The new owner of the policy, usually a corporate entity, was then responsible for tendering premiums due during the remainder of the insured's life to keep the policy in effect.³³ Sometimes this was unnecessary because many life insurance policies had a "waiver of premiums" clause. This meant that the insured wouldn't have to pay the premiums if s/he leaves work due to disability, after a short qualifying period.

³² The viatical section of the Criminal Issues chapter was adopted from the writing of Carole Fiedler, CEO and owner of Fiedler Financial and Innovative Settlement Solutions, a viatical/life settlement brokerage in San Rafael, California. ALRP wishes to thank Carole, who has been a licensed settlement professional since 1992, for her generosity in allowing us to use her work for this chapter of the Manual. ALRP also thanks Tanya Reeves, Esq. and Molly Stafford, Esq. for their writing contributions. The viatical section was edited by Tanya Reeves, Esq., Client Services Director of the AIDS Legal Referral Panel.

³³ Corporate entities that purchase life insurance policies are called either viatical and/or life-settlement provider or funding companies. Each provider company has specific purchasing parameters (criteria required to evaluate the profitability of the transaction), including minimum face values, policy type, health, and life expectancy. The methods used for financing purchases vary from company to company.

This arrangement worked well for many years. AIDS patients had access to desperately needed funds, and the viatical companies enjoyed a substantial profit with very little risk. Viatical brokers were usually used to facilitate these transactions, and they received a commission in exchange for gathering all necessary information and “shopping” the insurance policy around to many viatical companies looking for the best price.³⁴

Everything was going smoothly until people with AIDS stopped dying.

In 1996, at the Annual AIDS Conference in Vancouver, the news of a new drug type - protease inhibitors - was introduced. The reports were extremely positive for people with AIDS but devastating to the viatical industry. As life expectancies increased, viaticated policies dropped in value. Investors anticipated a fast profit but were left with a return that could be decades away. As a result, in the summer of 1996, Dignity Partners, Inc. of San Francisco, a leading viatical funder and the only one that had gone public at that time, announced that they would no longer purchase policies of people with HIV and AIDS.³⁵ Shortly thereafter, the San Francisco Department of Public Health and AIDS medical practitioners began to regard AIDS as chronic disease and not a terminal illness.

While all of that was going on, it became apparent that fraudulent get-rich-quick schemes were surfacing in the booming viatical industry. Unscrupulous viatical insiders and life insurance brokers, among others, solicited men with HIV/AIDS and encouraged them to buy multiple life insurance policies. By then, most of the life insurance applications had been modified to include a question about AIDS, and those infected were ineligible. Therefore, the broker instructed the applicant to lie about his/her HIV status on the application. The scheme was often presented as a “seminar” for people with AIDS at an AIDS service organization. Since it was out in the open and hosted by a reputable agency, it appeared to be legitimate. The viatical broker instructed the applicants to lie about their HIV/AIDS status, a process known as “clean sheeting.” A life insurance broker was usually present at these “seminars,” ready to sign people up for multiple policies. Then the viatical broker would immediately sell the policies to a viatical company, a practice known as “wet ink transactions.” The person with AIDS was given a small cut of the money. This practice was so common during the late 1990’s that many people did not question its legality.

If, within the first two years, the policy insurer discovered that the insured lied about having HIV/AIDS on the application, the policy became invalid and the viatical company lost its entire investment. Likewise, many viatical settlement companies had been hit so hard by the sudden life expectancy increase that they no longer had the cash flow to pay the premiums. The policies subsequently lapsed, and the entire policy's death benefit was lost. Another hardship viatical companies faced was people with AIDS returning to work, which opened up the possibility of terminating their life insurance policy. Most

³⁴ Both viatical brokers and viatical companies must be licensed by the California Department of Insurance. California also requires the person/entity who purchases previously viaticated policies to have a viatical license. Sections 101130 and 101132 of the California Insurance Code outline viatical licensing requirements.

³⁵ Chuck Coppola, CNN Interactive, *AIDS Research Project May Limit Life Insurance Options*, July 21, 1996, <http://www.cnn.com/HEALTH/9607/21/aids.insurance/>.

group policies had a “waiver of premiums” clause that discontinued when the insured returned to work. The monthly premiums were re-instated, which was not one of the costs originally calculated when the policy was purchased. Some policies contained a cancellation clause if the insured returns to work or if s/he is eligible for another life insurance policy. Upon obtaining new employment, many were offered a new group life insurance plan, which does not require a medical exam to determine eligibility.³⁶ For all of these reasons, the viatical industry began to sink.

Many investors sued the viatical companies and the policies were placed in receivership, where attempts were made to recover part of the original investments. Some policies were re-sold and the proceeds were distributed among the investors.³⁷ Many receivers turned to the viator for compensation. Unfortunately, the viatical payout had long since been spent. When asked for reimbursement, most viators were receiving disability benefits and not working. Unable to return the money, some were turned over to the United States Attorney General for investigation of fraud.

The United States Attorney General’s office began to pursue viatical schemes under the auspices of “mail fraud,” which provided federal jurisdiction.³⁸ Because the transactions and communications were facilitated by the United States Post Office, the brokers and viators had committed a federal offense. The prosecutors were really after the brokers, who had profited the most from the fraud, but often targeted the viators as well. Some of the viators were able to strike deals to testify against the broker in exchange for a lighter sentence. Other viators (particularly the ones who sold multiple policies or profited significantly) were prosecuted and convicted.

A client with a viatical matter usually contacts ALRP because of a pending civil or criminal investigation. The contact may originate from an attempt to collect restitution for the cheated investors, from a criminal complaint for fraud, or from a new viatical company that has recently purchased the life insurance policy. Some insurance policies are re-sold, and the new beneficiaries start to keep track of the insured. Anyone who purchases either an interest in or an entire policy (whether it is a company, an individual investor, or a group of investors) has an ongoing interest in and right to know the insured’s current health status and life expectancy, and to be advised upon the death of the insured. This is known as “tracking” and is established in the original contract of sale and other closing documents. In order to obtain access to this information, the viator must provide current authorizations and releases from time to time. Many viators are contacted in order to obtain this information.

³⁶ At this time, this is the best method for a person with HIV/AIDS to obtain life insurance. If s/he wants to viaticate it after the two-year contestability and suicide periods have passed, s/he will first have to convert it to an individual policy.

³⁷ Many were sold in bulk as a portfolio.

³⁸ 18 U.S.C. §63(1)(1996).

If an ALRP client has been contacted by a new policy owner, the first step requires analysis of the original contract of sale to determine what ongoing obligations the viator may have. In cases where viators were involved in clean sheeting, wet paper transactions, or multiple policy sales, they may be contacted in regard to their part in or knowledge about those transactions.

In the case of civil investigations, the receiver is charged with the task of reimbursement for the fraudulently obtained payouts. In this case, the receiver is only after money. If your client has any money at his/her disposal, you might propose an offer in compromise. One ALRP client settled a \$25,000 debt for \$1,200, and in some cases, receivers accept even less. In the case of state or federal criminal investigations, you may be able to negotiate a deal for immunity in exchange for testimony against the brokers. In cases where this is not possible, you can petition the judge for own-recognition release based on necessity of access to medical specialists.

If you have a client who is awaiting sentencing for fraud, you can petition the judge to take into consideration your client's illness and life expectancy. Sentencing judges are permitted to factor in these concerns when calculating the sentence. If the crime normally carries a twelve-month sentence, that is a small fraction of time in the life of other similarly situated convicts. For your client, that might be a death sentence. Judges have granted people with HIV/AIDS no jail time with court supervised probation, suspended sentences, and sentences for time served.

If your client has disabling HIV or AIDS and has already been sentenced (but has served less than 120 days), you can file a motion for Recall and Re-Sentencing.³⁹ This is a hearing that permits the sentencing judge to reconsider his/her sentence in consideration of facts that were unknown to the judge at the original sentencing hearing. You can present medical evidence/testimony about the impact incarceration will have on your client's health, including interruption of treatment protocol, access to specialists, restrictions in exercise and diet, exposure to contagious diseases that flourish in overcrowded prison settings, etc. The motion includes documentation of a job or source of income (i.e., SSDI) upon release, evidence that a caregiver has been procured, admission to a drug treatment program if applicable, documentation of housing upon release, etc. The judge is also concerned about risk to the community and recidivism, so offering evidence of rehabilitation would increase the chance of sentence modification. You can also introduce the issue of life expectancy in relationship to the length of the sentence.

If your client has AIDS and has been imprisoned for more than six months, s/he might qualify for a compassionate release, which commutes the sentence to time served and releases the inmate so s/he can die at home. Prisoners incarcerated for non-violent crimes are good candidates. Prison medical staff must diagnose your client with a life expectancy of less than six months. You should present a release plan, as described

³⁹ CAL. PENAL CODE §1170(d)(1998).

above, and a release community that would not expose the releasee to contact with former acquaintances who were involved in the viatical scam.