May 2, 2023

Senate Chair Julian Cyr
House Chair Marjorie C. Decker
Joint Committee on Public Health State
House Rooms 111 and 130
24 Beacon Street
Boston, MA 02133

Dear Chair Cyr, Chair Decker, and Members of the Joint Committee on Public Health,

Fenway Health would like to register opposition and deep concern to the following bills, as well as flag the unintended harm that they would cause if passed into law:

- **H.2177 and S.1349 An Act Relative to Healthcare Worker and First Responder Safety (Garlick and Cronin)**
- **H.2127 and S.1409 An Act relative to HLTV 111 tests (Ayers and Mark)**

Founded in 1971, Fenway Health advocates for and delivers innovative, equitable, accessible health care, supportive services, and transformative research and education. We center LGBTQIA+ people, BIPOC individuals, and other underserved communities to enable our local, national, and global neighbors to flourish. AIDS Action, the public health division of Fenway Health, aims to fight HIV health inequities by eliminating new infections, maximizing healthier outcomes for those living with HIV and at risk, and tackling the root causes of HIV/AIDS.

While we recognize that the sponsors of this legislation are well-intentioned, we are opposed to these bills, which would force individuals to get an HIV test and to disclose their HIV status without their consent. Though the goal of reducing the transmission of HIV is one we all wholeheartedly support, these bills do not accomplish that goal. **We are opposed to these bills for 3 main reasons.**

1. **They undermine current HIV privacy laws.**
2. **They are ineffective at protecting healthcare workers and first responders potentially exposed to HIV through an occupational exposure**.[1]
3. **These types of exposures are extremely rare.**

These bills would undermine and eliminate essential protections built into current HIV privacy laws. Chapter 111, Section 70F of the Massachusetts General Laws ensures no individual may be forced to get an HIV test against their will, and protects people from having their private HIV medical information disclosed without their consent. This law is in place to encourage people to get tested knowing their health information is protected. Allowing individuals to be tested without their knowledge or consent undermines those very protections. HIV is still a highly stigmatized condition, and disclosure still causes people to lose relationships, jobs, housing, and social acceptance in many

[1] "HIV and Occupational Exposure | HIV in the Workplace | HIV/AIDS | CDC," accessed May 1, 2023, https://www.cdc.gov/hiv/workplace/healthcareworkers.html.

settings. **These bills are ineffective at protecting healthcare workers and first responders potentially exposed to HIV through an occupational exposure.** The possibility of a false negative test result would mislead the person potentially exposed into a false sense of security about the need to take post-exposure treatment, contrary to guidelines issued by the U.S. Public Health Service.[2] These well recognized national guidelines recommend starting a post-exposure prophylaxis (PEP) regimen of anti- HIV medications as quickly as possible, within 72 hours of a high risk occupational exposure. While determining the HIV status of the source patient is advisable, such testing is recommended "without delaying PEP initiation in the exposed provider."

The HIV status of the source patient is also incomplete information, and does not solely determine initiation of PEP for another important reason. The individual tested could be in the "window period" between exposure and development of antibodies. This period can vary greatly among individuals, the longest time period being six months—meaning one can become infected with HIV but their immune system takes six months to produce the antibodies detected and measured in an HIV test. In the worst case scenario, an individual has recently become HIV infected, but is tested during the window period, resulting in a negative HIV antibody test. This could provide a dangerous sense of false security without a full evaluation of risks, and could serve as a disincentive to begin PEP for HIV prevention or to continue and finish that treatment regimen once started. It is worth noting that discontinuing PEP too early can cause complications later on if transmission actually occurred, and can limit future treatment options. While testing the source patient can be helpful information, it is only useful in the general context of ascertaining risk looking at a variety of factors.

HIV is a virus of extremely low transmission in occupational settings. *Nationally, there have only been 58 confirmed cases of occupational HIV transmission to health care personnel since the beginning of the AIDS epidemic, and only one in the last twenty years.*[3] That one case, in 2008, involved laboratory personnel working with highly infections live HIV cultures, not a scenario envisioned in these bills. Most of the 58 transmissions occurred before the advent of standard universal precautions, infection control procedures, and the development of new safety devices. It is critical to evaluate the utility of this bill in light of the relatively minimal risk of occupationally acquired HIV, and the tools we have available to minimize that risk to near zero.

With the risk of HIV infection from occupational exposure at near zero, what problem are these bills actually trying to solve? The answer is likely rooted in the understandable fear of HIV. It is that same fear and stigma around HIV that makes our state's HIV privacy laws still so essential. Public safety officials, health care personnel, and other individuals with a perceived risk of acquiring HIV deserve timely and comprehensive counseling, treatment, and access to PEP, whenever warranted. They deserve our compassion and understanding for the fears associated with HIV. But as a matter of policy, our state laws and institutional policies should be based on science and not fear.

Another concern underlying these bills is anxiety around taking PEP. Historically, HIV medications, including those used for PEP, were limited to a few options, each of which had higher levels of side effects and drug interactions than we see today. This made the regimens of the past more difficult to

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[2] "Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis.," accessed May 1, 2023, https://stacks.cdc.gov/view/cdc/20711.

[3] "Notes from the Field: Occupationally Acquired HIV Infection Among Health Care Workers — United States, 1985–2013," accessed May 1, 2023, https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6353a4.htm.

adhere to, creating additional anxiety. HIV medications, both for treatment and for PEP, have been significantly improved in recent years. Many HIV regimens now exist that are one pill a day, easily tolerated with minimal to no side effects, far better safety profiles than earlier options, and those improvements have continued even in the last few years with new and better regimens available. That doesn't mean there isn't stress associated with taking such regimens, but stress can be managed with sensitivity and appropriate support from occupational health and medical professionals.

Institutions with high rates of occupational injuries have an obligation to protect the safety and well-being of their staff, review standard procedures designed to minimize such occurrences, and to provide appropriate treatment and referrals. Ultimately, the best course of action when confronting a potential exposure is to follow national guidelines, assess the actual risk of transmission, begin PEP if warranted, and continue to ensure access to counseling and voluntary HIV, hepatitis B and hepatitis C screening. Institutions should also be offering HIV testing as a matter of routine care for all adults, as recommended by the CDC.[4] This would be one of the most effective ways of ensuring everyone living with HIV knows their status, is able to get treatment and reduces the spread of HIV.

We respectfully urge the committee to grant an unfavorable report to H.2177, S.1349, H.2127 and S.1409. Taken together, these bills would strip essential privacy protections from people living with HIV, create more risk for staff who are potentially exposed, dis-incentivize healthcare institutions from providing comprehensive procedures and support for staff at risk of exposure, and are based on fear and stigma—not science and well- researched policy recommendations.

We would happily work with this committee, as well as the sponsors of these bills, who, again, we know to be well intentioned, to achieve our common goal of eliminating HIV infections, reducing the stigma and fear associated with HIV, and ensuring our workforce has the tools and resources they need to do their jobs safely without harmful policy changes. Thank you.

Sincerely,

Sean Cahill, PhD
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The Fenway Institute, Fenway Health