

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division**

ISAAH WILKINS, *et al.*,

Plaintiffs,

v.

LLOYD AUSTIN III, in his official capacity as Secretary of Defense, *et al.*,

Defendants.

Case No. 1:22-cv-1272 (LMB/IDD)

**DEFENDANTS' MEMORANDUM OF LAW IN SUPPORT OF
MOTION FOR SUMMARY JUDGMENT AND IN OPPOSITION TO PLAINTIFFS'
MOTION FOR SUMMARY JUDGMENT**

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Ex. 1	Declaration of Dr. Paul Ciminera (“Ciminera Decl.”).
Ex. 2	Declaration of Ms. Angelia K. Holbrook (“Holbrook Decl.”).
Ex. 3	Declaration of Colonel Christopher L. Evans (“Evans Decl.”).
Ex. 4	Declaration of Colonel Jason M. Blaylock (“Blaylock Decl.”).
Ex. 5	Declaration of Mr. Charles Huntsinger (“Huntsinger Decl.”).
Ex. 6	Letter of Sec’y of Def. Lloyd Austin, III, <i>Policy Regarding Human Immunodeficiency Virus-Positive Personnel Within the Armed Forces</i> , June. 6, 2022 (“June 6 Mem.”).
Ex. 7	Letter of U.S. Solicitor General Elizabeth Prelogar, regarding <i>Harrison v. Austin</i> , No. 18-cv-641, and <i>Roe v. Austin</i> , No. 18-cv-1565, June 7, 2022 (“530D Letter”).
Ex. 8	Dep’t of Def. Instruction (“DoDI”) 6130.03, Vol. 1, <i>Medical Standards for Military Service: Appointment, Enlistment, or Induction</i> , (Change 4 effective Nov. 16, 2022) (“DoDI 6130.03”).
Ex. 9	DoDI 6485.01, <i>Human Immunodeficiency Virus (HIV) in Military Service Members</i> , (Change 2 effective Jun. 6, 2022) (“DoDI 6485.01”).
Ex. 10	DoDI 6490.07, <i>Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees</i> , (Feb. 5, 2010) (“DoDI 6490.07”).
Ex. 11	Army Regulation (“AR”) 40-501, <i>Standards of Medical Fitness</i> , (Mar. 17, 2023) (“AR 40-501”).
Ex. 12	AR 600-110, <i>Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus</i> , (Jun. 27, 2014) (“AR 600-110”).
Ex. 13	USCENTCOM Individual Protection and Individual Unit Deployment Policy, Mod-17, 2023 (“MOD-17”).
Ex. 14	Tab A to USCENTCOM Individual Protection and Individual Unit Deployment Policy, (“MOD-17, Tab A”).
Ex. 15	Dep’t of Health & Human Servs. (“HHS”), <i>Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV</i> , https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv (“HHS ART Guidelines”).
Ex. 16	CDC, <i>Evidence of HIV Treatment and Viral Suppression in Preventing the Sexual Transmission of HIV</i> , https://www.cdc.gov/hiv/risk/art/evidence-of-hiv-treatment.html (accessed Jun. 25, 2023) (“Evid. of HIV Treatment & Viral Supp.”).
Ex. 17	CDC, <i>Updated Guidelines for Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV – United States, 2016</i> (“Nonoccupational Exposure Guidelines”).

Ex. 18	Center for Disease Control (“CDC”), <i>Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis</i> (2013, updated 2018) (“ <i>Occupational Exposure Guidelines</i> ”).
Ex. 19	CDC, <i>Recommendations for Postexposure Interventions to Prevent Infection with Hepatitis B Virus, Hepatitis C Virus, or Human Immunodeficiency Virus, and Tetanus in Persons Wounded During Bombings and Similar Mass-Casualty Events – United States, 2008</i> , MMWR, Morbidity & Mortality Weekly Report, Vol. 57, No. RR-6 (Aug. 1, 2008) (“ <i>CDC Mass Casualty Recommendations</i> ”).
Ex. 20	Nat’l Insts. of Health (“NIH”), <i>10 Things to Know About HIV Suppression</i> , https://www.niaid.nih.gov/diseases-conditions/10-things-know-about-hiv-suppression (accessed Jun. 25, 2023).
Ex. 21	Food & Drug Admin. (“FDA”), <i>Revised Recommendations for Reducing the Risk of Human Immunodeficiency Virus Transmission by Blood and Blood Products</i> (Mar. 13, 2023) (“ <i>FDA Donation Recommendations</i> ”).
Ex. 22	Jt. Trauma Sys. Clinical Practice Guideline, <i>Whole Blood Transfusion</i> , (May 15, 2018) (“ <i>Whole Blood Transfusion</i> ”).
Ex. 23	N.Y. State Dep’t of Health AIDS Inst., <i>PEP to Prevent HIV Infection</i> (updated Aug. 11, 2022).
Ex. 24	Hakre et al., <i>Transfusion-Transmissible Viral Infections Among U.S. Military Recipients of Whole Blood and Platelets During Operation Enduring Freedom and Operation Iraqi Freedom</i> , <i>Transfusion</i> , Vol. 51, 473-485 (March 2011) (“Hakre 2011”).
Ex. 25	Hakre et al., <i>Transfusion-Transmitted Human T-Lymphotropic Virus Type I Infection in a U.S. Military Emergency Whole Blood Transfusion Recipient in Afghanistan, 2010</i> , <i>Transfusion</i> , Vol. 53, 2176-82 (Oct. 2013) (“Hakre 2013”).

INTRODUCTION

Defendants do not dispute that with proper adherence to medication, HIV is a manageable condition for nearly all people living with HIV (“PLWH”). For adherent individuals, the risk of transmitting the disease is low, and for PLWH with an undetectable viral load, there is effectively no risk of sexual transmission. However, because the military must be prepared to send service members to combat, the military is principally concerned with *bloodborne* transmission. The absolute risk of bloodborne transmission on the battlefield is unquantifiable. It might be low, but the military judges it to be meaningful. For that and other reasons, the military has exercised its discretion to restrict PLWH from joining the armed services, a process known as “accession.”

The Court has previously considered and enjoined aspects of military policies relating to PLWH. Since that time, the Department of Defense (“DoD”) has modified its deployment policy to ensure there is no categorical bar to the deployment of PLWH and has affirmed that no PLWH will be separated solely on the basis of HIV status. But the calculus of deciding whether to allow someone to *join* the military is different. Even though the military allows PLWH to deploy, HIV-related concerns remain, including the possibility of a worsening condition, transmission of the disease, and other risks. And even though the military does not *categorically* deny deployment based on HIV-status, there may be *particular* deployments for which the risks of deploying someone with HIV are too high. Thus, while the military will not separate an already-serving member solely because of HIV-status, it is rational for the military to decline to take on an individual presenting these known risks. That is particularly true given that the military may rationally treat a currently serving member differently given the resources it has already invested in that person.

Moreover, there are additional rational justifications to restrict the accession of PLWH. The military would incur substantially greater costs on a per-person basis by enlisting PLWH

compared to someone without HIV. Restricting accession of PLWH thus conserves military resources. In addition, some countries impose restrictions on entry of PLWH. The U.S. military generally does not deploy PLWH to countries with strict bans to preserve relations with those nations. Because the military seeks to recruit individuals who can deploy worldwide, it is rational for the military to deny the accession of PLWH given these inherent deployability restrictions.

It is Plaintiffs' burden to refute every conceivable rational basis supporting the HIV accession policy. Because the accession policy is supported by multiple rational justifications, the policy must be upheld, Plaintiffs' motion denied, and judgment entered in favor of Defendants.

STATEMENT OF UNDISPUTED FACTS ("SUF")

I. Policy and Regulatory Background

1. The U.S. military seeks recruits in excellent physical and medical health. Ciminera Decl. ¶ 7; *see* 10 U.S.C. § 505(a). The military's accession standards are typically more restrictive than the "retention" standards used to determine whether to separate someone from the military who has developed a new medical condition. Ciminera Decl. ¶ 7. That is so in part because the military has already invested resources in a service member facing a retention decision, and also in part because at the accession stage the military seeks to avoid taking on certain known risks. *Id.*

2. Numerous regulations govern military accession policy. Principal among them is Department of Defense Instruction 6130.03, Vol. 1, *Medical Standards for Military Service: Appointment, Enlistment, or Induction* ("DoDI 6130.03," attached as Ex. 8). *See id.* § 1.2(a). Per DoDI 6130.03, § 1.2(d), it is DoD policy to ensure that individuals joining the military are:

- (1) Free of contagious diseases that may endanger the health of other personnel.
- (2) Free of medical conditions or physical defects that may reasonably be expected to require excessive time lost from duty for necessary treatment or hospitalization, or may result in separation from the Military Service for medical unfitness.

- (3) Medically capable of satisfactorily completing required training and initial period of contracted service.
- (4) Medically adaptable to the military environment without geographical area limitations.
- (5) Medically capable of performing duties without aggravating existing physical defects or medical conditions.

3. To advance those goals, DoDI 6130.03 provides a list of hundreds of medical conditions that are presumptively disqualifying for military service. Ex. 8, DoDI 6130.03, § 6.1. The disqualifying conditions are grouped into dozens of different health systems, such as conditions related to vision, hearing, dental health, and various body parts and organ systems. *See id.* § 6.

4. Studies show that PLWH with an undetectable viral load have effectively no risk of transmitting HIV sexually. Blaylock Decl. ¶ 38. But there are no equivalent studies indicating that individuals with an undetectable viral load cannot transmit HIV through blood-to-blood exposures. *Id.*; Ex. 15, *HHS ART Guidelines*, at F-5 (“The effectiveness of [relying on an undetectable viral load] to prevent transmission from blood exposure . . . has not been determined.”).

5. Infectious diseases are of particular concern to the military. *See* Ex. 8, DoDI 6130.03, § 1.2(d)(1). Accordingly, it is disqualifying if an individual has “[a]ny current acute pathological conditions, including but not limited to communicable, infectious, parasitic, or tropical diseases, until recovery has occurred without relapse or sequelae.” *Id.* § 6.30(a).

6. DoDI 6130.03 lists numerous infectious conditions that are generally disqualifying. *See, e.g., id.* § 6.10(c)-(d) (infectious pneumonia); § 6.12(c)(2) (infectious colitis); § 6.12(d)(1) (“chronic Hepatitis B unless successfully treated and the cure is documented”); § 6.12(d)(2) (“chronic Hepatitis C, unless successfully treated and with documentation of a cure”); § 6.23(c) (tuberculosis); § 6.23(d) (syphilis “without appropriate documentation of . . . cure”); § 6.23(s) (active systemic fungus infection or history of systemic fungal infection “unless resolved”).

7. HIV is also a disqualifying condition under DoDI 6130.03 except as to “covered personnel” for in-service accession. *Id.* § 6.23(b); Ciminera Decl. ¶¶ 18-19. DoDI 6130.03 was amended in June 2022 to allow “covered personnel” (certain virally suppressed, already serving PLWH) to be appointed as officers upon case-by-case consideration. Ex. 8, DoDI 6130.03, § 6.23(b); Ex. 6, June 6 Mem., at 1. However, HIV is still generally a disqualifying condition for individuals who are not currently serving. Ex. 8, DoDI 6130.03, § 6.23(b); Ciminera Decl. ¶ 18.

8. In general, DoDI 6130.03 allows an individual with a disqualifying medical condition to seek a medical waiver. Ex. 8, § 1.2(e). However, whenever an infectious disease is identified during an initial application process, the military advises that the applicant undergo and confirm appropriate treatment of the infectious disease prior to an accession waiver being granted. Blaylock Decl. ¶ 47. For bloodborne diseases that are incurable, the military has a low tolerance of transmission risks and generally seeks to minimize those risks by denying waivers. *See id.*

9. Another regulation, DoDI 6485.01, states that it is DoD policy to “[d]eny eligibility for military service to persons with laboratory evidence of HIV infection for appointment . . . enlistment, pre-appointment, or initial entry training for military service.” Ex. 9, § 3(a). DoDI 6485.01 recognizes that “covered personnel” may seek appointment as officers. *Id.* The regulation also requires that “the cognizant Combatant Command surgeon will be consulted in all instances of HIV seropositivity before medical clearance for deployment.” *Id.*, Encl. 3, § 2(b).

10. The DoD provides guidance on whether medical conditions could limit deployability through DoDI 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees* (attached as Ex. 10). The medical standards provided in that regulation are mandatory for “contingency deployments,” *id.* § 4(a), which are deployments outside the continental United States, over 30 days in duration, in a location with only temporary military medical

treatment facilities, and in which there is a situation requiring military operations in response to certain events, *see id.* § 3(a), (b). DoDI 6490.07 contains a list of medical conditions that generally preclude a Service member from deploying “unless a waiver is granted.” *Id.*, Encl. 3. Waivers are sought from the Combatant Commander. *Id.*, Encl. 2, § 3. DoDI 6490.07; *see id.*, Encl. 3, § e(2).

11. A “combatant command” is a military entity that provides unified authority over military units within a defined geographic region. The combatant commands may provide additional guidance regarding the medical requirements for deployment. For example, the U.S. Central Command provides such guidance in *Modification Seventeen to USCENTCOM Individual Protection and Individual-Unit Deployment Policy* (“MOD-17,” attached as Ex. 13). If a service member is asymptomatic and has an undetectable viral load, then he or she may deploy to Central Command “dependent on host nation requirements.” Ex. 14, MOD-17, Tab A, ¶ 7(c)(2).

12. The Army must set accession standards that are at least as strict as DoD standards. Holbrook Decl. ¶ 8 (attached as Ex. 2). The Army implements DoDI 6130.03 through Army Regulation (“AR”) 40-501, *Standards of Medical Fitness* (attached as Ex. 11), which designates HIV as a disqualifying condition. AR 40-501, ¶ 3-26(j); Holbrook Decl. ¶ 9. The Army implements DoDI 6485.01 through AR 600-110, *Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus* (attached as Ex. 12), which states that “HIV infected personnel are not eligible for appointment or enlistment.” Holbrook Decl. ¶ 9. While appropriately authorized officials in the Army may generally grant exceptions to policies that were promulgated by the Army, they may not do so when the exception would conflict with DoD policy. *Id.* ¶ 10.

II. Medical Background of HIV

13. HIV is an incurable, infectious disease. Blaylock Decl. ¶ 5. It can be transmitted through sexual contact, blood transfusion, other blood-to-blood contact, and other means. *Id.* ¶ 36.

14. HIV can be managed through effective use of antiretroviral medications (“ART”). Blaylock Decl. ¶ 13. With proper adherence, most PLWH can keep their viral load suppressed. *Id.* “Viral load” refers to the number of copies of the HIV virus per milliliter of blood. *Id.* ¶ 5 n.2.

15. If an individual with a suppressed viral load stops taking their medication, their viral load will begin to increase – a process known as “viral rebound” – and the individual will eventually no longer be virally suppressed. Blaylock Decl. ¶ 31. Typically, viral rebound will occur within two-to-eight weeks, but it can occur more quickly. *Id.* HHS guidelines about ART treatment state that “[v]iral rebound typically occurs within days to weeks after ART cessation and has been observed as early as 3 to 6 days after stopping treatment.” Ex. 15, *HHS ART Guidelines*, at F-3.

16. Many individuals do not properly adhere to ART medication. Blaylock Decl. ¶ 13. While proper adherence to ART medication will result in viral suppression for most patients, there are some patients who will not achieve viral suppression even with adherence. *Cf. id.* Insufficient adherence to an ART regimen can lead to resistance to ART treatments. *Id.* ¶ 33. The minimum level of adherence required to maintain viral suppression is uncertain, particularly for newer regimens. *Id.* ¶ 31. Some medical studies only deem individuals “adherent” if they take 95% of daily medication. *Id.*; see Ex. 20, NIH, *10 Things to Know about HIV Suppression*, at 4 (“It is essential to continue to take every pill every day as directed to maintain an undetectable viral load.”).

17. As of 2019, approximately one-third of the PLWH in the United States were not virally suppressed. Ex. 15, *HHS ART Guidelines*, at L-2; Ex. 16, CDC, *Evid. of HIV Treatment & Viral Supp.*, at 2; Blaylock Decl. ¶ 13. A recent study, using data from a single clinic, found that the average rate of adherence to ART medication was 84.9%. Blaylock Decl. ¶ 13.

18. HIV can be transmitted through various blood-to-blood exposure routes. *Id.* ¶ 36. Blood transfusion is the mode of transmission most likely to lead to infection. The CDC has

reported that if HIV-infected blood is transfused into an HIV-negative individual, there is an estimated 92.5% chance of transmission. Ex. 17, *CDC Nonoccupational Exposure Guidelines*, at 25. Even if an individual has an undetectable viral load, the risk of transmission via blood transfusion is substantial given the amount of blood that may be transferred. Blaylock Decl. ¶ 43.

III. Risks Presented by HIV in the Military Context

A. Viral Rebound

19. Conditions of contingency deployments may increase the risk that PLWH will not maintain strict adherence to their ART medications. Blaylock Decl. ¶¶ 29-32. Those conditions may include constant movement, lack of sleep, high stress, irregular daily activities, and operations away from base in which a service member might not carry extra medication. *Id.* ¶ 32.

20. Contingency deployments present increased risks of medicine being lost or destroyed. *See* Blaylock Decl. ¶ 29. If that happens, the service member likely would not be able to immediately obtain their medication regimen from existing supplies, and logistics challenges could make it difficult to replace the medication. *See id.* ¶¶ 29-30. In near-peer conflicts (meaning conflicts with other countries with military capabilities that approach those of the United States), the U.S. military might not have air superiority, re-supply could be further delayed given logistical challenges, and it might take months before ART medication could be re-supplied. *Id.* ¶ 30.

B. Blood Transfusions

21. Access to safe blood for use in emergency blood transfusions is a critical element of combat medical care. Evans Decl. ¶ 5. When transfusions are necessary, the military's first preference is to use stored blood that has been pre-screened for diseases. *Id.* ¶ 7; Ex. 22, *Whole Blood Transfusion*, at 5. However, that option is not always available. Stored and pre-screened blood is normally only kept at military medical facilities rated as "Role 2" or higher, and blood

transfusions frequently need to be performed before reaching such a facility.¹ Evans Decl. ¶ 7. Stored and pre-screened blood may quickly be depleted in mass-casualty events. *Id.* This is a common occurrence in combat and is expected to remain so in future potential conflicts. *Id.*

22. When stored blood supplies are unavailable, the military seeks additional blood supplies from a “walking blood bank,” in which individuals are asked to donate blood for near-immediate transfusion. Evans Decl. ¶ 8. When a walking blood bank is activated, the most-preferred donors are U.S. service members who have been pre-identified and pre-screened for diseases, other service members who report recently having given blood are called on next, followed by service members who have not been pre-screened. *Id.* Coalition partner military forces should not be utilized routinely “due to national variances in screening for blood borne diseases and differences in disease prevalence,” and foreign nationals who are not part of a partner military force should be used only “as a last resort.” Ex. 22, *Whole Blood Transfusion*, at 5; see Evans Decl. ¶ 8.

23. When activating the walking blood bank, the military takes precautionary measures to limit the risk of transmitting diseases. Evans Decl. ¶ 10. The FDA recommends that individuals who have ever tested positive for HIV not be allowed to give blood. Ex. 21, *FDA Donation Recommendations*, at 8. The military instructs PLWH that they are not allowed to give blood. Evans Decl. ¶ 10. The military will also screen donated blood for bloodborne diseases (including HIV) “to the greatest extent possible.” Ex. 22, *Whole Blood Transfusion*, at 6; Evans Decl. ¶ 11. However, that is not always possible, and military procedures for the walking blood bank presuppose that such testing may not occur during exigent circumstances. See Ex. 22, *Whole Blood*

¹ There are four echelons or “roles” of military medical care. Roles 1, 2, and 3 appear in combat environments. Role 1 involves unit-level care, and generally includes a doctor, a physician’s assistant, and combat medics. Role 2 and 3 facilities have progressively greater capabilities. Role 4 facilities are found in U.S. base hospitals and robust overseas facilities. See Evans Decl. ¶ 7 n.2.

Transfusion, at 5; Evans Decl. ¶ 11. In addition, rapid HIV tests are subject to various limitations. Due to temperature storage restrictions, they generally are only located at Role 2 medical facilities or higher. *Id.* When they are available, rapid HIV tests are not FDA-approved for screening planned blood transfusions, and they may take up to twenty minutes or more to return a result, limiting their effectiveness when transfusions need to occur quickly. *Id.*; Blaylock Decl. ¶ 38.

24. The military has documented at least one case of hepatitis C and one case of Human T-lymphotropic virus (HTLV) being transmitted through the walking blood bank. Blaylock Decl. ¶ 42; Ex. 24, Hakre 2011, at 478-480 (hepatitis C); Ex. 25, Hakre 2013, at 2176 (HTLV). Service members who know they have HIV could still pose a risk of donating blood to the walking blood bank, notwithstanding the fact they have been informed they should not donate. Blaylock Decl. ¶ 42. Even though there have only been a few documented examples of bloodborne transmission through the walking blood bank, the military nonetheless seeks to minimize the risks that are in its control. The military assesses there is a meaningful risk that a service member might donate blood for reasons such as: (1) to avoid revealing that he or she is living with HIV; (2) as a result of peer pressure to donate, and (3) as a result of a value judgment that donating blood in an emergency situation is worth the risk of possible infection, among others. *Id.* The military knows of at least one instance in which an individual with a bloodborne infection (hepatitis C) donated to a walking blood bank despite knowing he was infected. Ex. 24, Hakre 2011, at 478-80.

25. In small units, an individuals' inability to donate blood, as in the case of an HIV-positive service member, Evans Decl. ¶ 10, increases risk to the entire unit. Blaylock Decl. ¶ 42. Military planning considers the possibility of conflict with "near-peer" adversaries. Blaylock Decl. ¶ 44. Military models have indicated that the need for blood supplies would be substantially greater in near-peer conflicts than was the case in the recent conflicts in Iraq and Afghanistan. *Id.* The

military performed more than 6,000 walking blood bank transfusions in Iraq and Afghanistan, but project more frequent use would be necessary in near-peer conflicts. Evans Decl. ¶¶ 7, 12; Blaylock Decl. ¶ 44. That is so because of the likely need for greater volumes of blood and greater difficulty in distributing blood products to the field. *See* Blaylock Decl. ¶ 44; Evans Decl. ¶ 12.

26. While already accessed PLWH are not categorically ineligible to deploy, the various risks associated with HIV may, in certain appropriate circumstances, mean that they would be denied particular deployments. Blaylock Decl. ¶ 25.

C. Other Blood-to-Blood Transmission Routes

27. There are various instances in which HIV transmission could occur via blood-to-blood exposure in military settings. *See* Blaylock Decl. ¶¶ 36, 39. Combat medical care presents a meaningful risk of transmission, from an HIV-positive patient to a caregiver or vice versa, and the risk of transmission during medical care is greater in combat than civilian settings. *Id.* ¶ 39.

28. No studies have estimated the risk of HIV transmission during combat medical care, and quantifying that risk may be impossible. Blaylock Decl. ¶ 40. Studies have estimated the per-act risk of HIV transmission from a “percutaneous injury” to be approximately 0.23%. *See* Ex. 17, CDC, *Nonoccupational Exposure Guidelines*, at 25. The CDC notes that one factor that may increase the risk of HIV transmission is “high viral load,” *id.*, so that estimate likely may increase or decrease based on whether an individual has a well-managed viral load. A “percutaneous injury” is an injury that pierces the skin, such as “a needlestick or cut with a sharp object.” Ex. 18, at 9. The level of risk from a percutaneous injury likely is increased by several factors, including larger volumes of blood, deep injuries, and higher viral loads. *See, e.g., id.* at 10; Blaylock Decl. ¶ 36.

29. A percutaneous injury involving HIV-infected blood presents a substantial risk of transmission and requires prompt intervention. Blaylock Decl. ¶ 40. CDC guidance states that

“[o]ccupational exposures to HIV” such as percutaneous injuries “should be considered urgent medical concerns and treated immediately.” Ex. 18, *Occupational Exposure Guidelines*, at 21. Likewise, in other guidance the CDC defined a “substantial risk for HIV acquisition” as including exposure of a “percutaneous contact” with blood from a source known to be HIV-positive. Ex. 17, CDC, *Nonoccupational Exposure Guidelines*, at 23. The New York State Department of Health AIDS Institute states that “[a]n HIV exposure is a medical emergency” and notes that “rapid initiation” of prophylactic measures “is essential to prevent infection.” Ex. 23, *PEP to Prevent HIV Infection*, at 11. That agency classifies a “[p]enetrating injury, such as a needlestick” that is exposed to blood as a “[h]igher-[r]isk HIV exposure” that requires prompt intervention. *Id.* at 16.

30. The risk of HIV transmission during combat medical care is higher than the risk presented in civilian medical care. Blaylock Decl. ¶¶ 39-40. Combat trauma involves greater volumes of blood than found in civilian contexts, increasing the potential amount of virus exposure. *Id.* ¶ 39. The person providing aid may have open wounds, be covered with abrasions, or otherwise have nonintact skin that provides a blood-to-blood exposure, particularly if the first responder was involved in the attack that harmed the patient. *Id.* Combat medical care also increases the risk to the medical caregiver given the nature of the wounds: combat medics and surgeons dealing with combat trauma may need to place their hands inside deep wounds, and those wounds may frequently have embedded shrapnel or sharp bones that can cut the hands of the caregiver and thereby create another blood-to-blood transmission route. *Id.* Needlesticks are not rare and likely are more common in combat medical care than in civilian care. *Id.* ¶ 39. Moreover, often during combat medical care, caregivers are unable to employ “universal precautions,” such as using sterile gloves, and often lack means to try to remedy blood-to-blood contact, such as sanitizers, soap, and running water, that would otherwise be available in civilian medical care environments. *Id.*

31. If an individual is exposed to blood from a known HIV-infected source via a percutaneous injury, U.S. medical authorities recommend that the exposed person begin a medication regimen known as “post-exposure prophylaxis,” or “PEP.” *See, e.g.,* Ex. 18, *Occupational Exposure Guidelines*, at 3, 21. PEP typically consists of a four-week regimen of ART medication. *Id.* at 3, 12. The effectiveness of PEP is time-sensitive: it should be started as soon as possible after exposure and may be ineffective 72 hours after exposure. *See id.* at 3, 21; Ex. 23, *PEP to Prevent HIV Infection*, at 3 (“PEP should be initiated immediately – ideally within 2 hours of an exposure but no later than 72 hours after an exposure[.]”); Blaylock Decl. ¶ 21. The CDC recommends that PEP be initiated even when the source of the HIV-infected blood has an undetectable viral load. Ex. 18, *Occupational Exposure Guidelines*, at 10-11 (“Exposure to a source patient with an undetectable serum viral load does not eliminate the possibility of HIV transmission or the need for PEP and follow-up testing.”). In accordance with this guidance, if a service member’s blood were exposed to HIV-infected blood, the military would attempt to offer PEP. Blaylock Decl. ¶ 40.

32. If PEP is prescribed, medical follow-up is required. CDC Guidelines generally recommend baseline testing at the time of exposure, with follow-up viral load testing at 6 weeks, 12 weeks, and 6 months after exposure. Ex. 18, *Occupational Exposure Guidelines*, at 27; Blaylock Decl. ¶ 41. If a soldier had blood-to-blood contact with a known HIV-positive source, the military would likely try to remove the soldier from the field for this viral load monitoring and other treatment. Blaylock Decl. ¶ 41. If the person who needed to be removed was a medical caregiver, that evacuation would limit the military’s ability to provide care to other service members. *Id.*

33. Another route of potential HIV infection in the military context is through the possibility of infected blood being exploded directly into the body of another person. The CDC has recognized the possibility of infection via this route, based in part on studies that detected

bloodborne pathogens in bone shards that had been implanted in the body of a suicide bombing survivor. *See* Ex. 19, *CDC Mass Casualty Recommendations*, at 2; Blaylock Decl. ¶ 45; *see also* Ex. 19, at 3 (discussing ways in which mass-casualty events may increase risk of transmission). The CDC states that “[b]ecause of the potential toxicities of antiretroviral drugs, PEP is recommended unequivocally only for exposures to sources known to be HIV-infected.” *Id.* at 6.

D. Side Effects and Comorbidities Associated with HIV and ART

34. HIV infection is also associated with various comorbidities, including cardiovascular disease, osteoporosis, cognitive dysfunction, and certain cancers. Blaylock Decl. ¶ 9. These conditions tend to develop at younger ages for PLWH compared to the uninfected population. *Id.* Comorbidities such as hypertension, myocardial infarctions, peripheral vascular disease, liver disease, renal disease, and non-AIDS cancers tend to be more commonly diagnosed in PLWH who have untreated or poorly controlled disease; however, they nonetheless remain prevalent for individuals with a well-controlled HIV infection. *Id.* ¶ 10.

35. Common ART regimens are associated with bone mineral density loss, renal dysfunction, weight gain, and increased lipid profiles. Blaylock Decl. ¶ 12. The clinical implications of these findings are not yet known, but the military medical community is concerned about how a side effect such as weight gain could affect an HIV-infected service member’s ability to maintain standards for medical readiness. *Id.* Neurocognitive issues, which have been associated with PLWH (though the cause of these issues remains unknown) are also of concern. *Id.* ¶ 11.

36. Side effects and comorbidities associated with HIV can occur in virally suppressed patients and may not present for years. Ciminera Decl. ¶ 39. These comorbidities may change over time. *Id.* Some conditions associated with military deployment and training, such as dehydration, lack of sleep, lack of regular meals, and disruptions in medication, may aggravate side effects of

certain infections. *Id.* ¶ 40. While data regarding those effects on HIV-specific conditions is limited, that uncertainty has been taken into account by the military. *See id.* ¶¶ 22-24, 40.

IV. Other Military Concerns Relating to HIV

A. Financial Considerations

37. The financial costs associated with medical conditions are among the factors considered by the military in setting accession standards, including for HIV. Ciminera Decl. ¶¶ 10, 22, 41. After issuance of the June 6, 2022 policy memorandum, the DoD convened a working group to consider certain issues associated with military HIV policy. *Id.* ¶ 43. That working group conducted assessments relating to the financial costs associated with HIV-positive service members. *See id.* ¶¶ 43-54. The working group estimated that the annual medical care costs of a service member living with HIV would be, on average, approximately \$15,654, which is approximately six times the average medical care costs of a service member without HIV. *Id.* ¶ 49.

38. To calculate the expected financial costs the military would incur if it were to allow PLWH to access, the military estimated that approximately 89 new PLWH would join per year, and that there would be approximately 300 additional PLWH in the military at any given time. Ciminera Decl. ¶¶ 44-46, 49. The policy change would result in the military incurring an estimated additional annual cost exceeding \$13.63 million, with the average additional cost per service member being approximately \$153,000 per person, per year. *Id.* ¶ 52; *see id.* ¶¶ 43-54.

B. Foreign Relations

39. In general, the DoD's military and civilian presence in foreign countries ("host nations") is exclusively by consent or invitation of the host nation. Ex. 5, Huntsinger Decl. ¶ 4.

40. Although the DoD is not bound to comply with host nation laws, it has a longstanding policy of respecting those laws to preserve its relationship with host nations. *Id.* ¶¶ 5-7. The

DoD binds its personnel to comply with various host nation laws through regulations and other guidance. *Id.*; *id.*, Ex. B CENTCOM Gen. Order No. 1B (2006) ¶¶ 1, 2(c), 2(e), 2(g). Respecting such laws and customs preserves relations between the United States and host nations and ensures force readiness. Huntsinger Decl. ¶ 6; *id.*, Ex. A CENTCOM Gen. Order No. 1D (2020), ¶ 1.

41. Some host nations within Central Command prohibit the entry or require the deportation of PLWH. Huntsinger Decl. ¶ 8. CENTCOM policy has long acknowledged these restrictions and indicated that they cannot be overridden. *Id.* Ex. C, USCENTCOM Individual Protection and Individual Unit Deployment Policy, MOD-13, Tab A ¶ 7(C)(2); ¶ 7(C)(5).

42. After the June 6, 2022, policy change concerning deployment, certain HIV-positive service members may deploy to the CENTCOM AOR, but approval of the deployment waiver is dependent on the legal restrictions of the specific host nation to which the service member will deploy. Huntsinger Decl. ¶¶ 10, 12; Ex. 13, MOD-17, ¶ 15.G.1; Ex. 14, MOD-17, Tab A, ¶ 7(C)(2).

43. The DoD might not deploy covered personnel to host nations that explicitly prohibit the entry or presence of HIV-positive foreign nationals, as doing so could damage trust between the United States and host nations and endanger individual HIV-positive service members. Huntsinger Decl. ¶¶ 10-12. Since the change in policy, CENTCOM has approved various waivers to deploy to the CENTCOM AOR for covered personnel and has also denied several deployment waivers for covered personnel to host nations which specifically prohibit their presence. *Id.* ¶ 12.

RESPONSE TO PLAINTIFFS' LISTING OF UNDISPUTED FACTS

Many of the paragraphs listed in Plaintiffs' Listing of Undisputed Facts ("PLUF") have no factual support and instead cite only previous judicial decisions. *See* PLUF ¶¶ 1-10, 16-17, 19-20, 23, 2-28, 31-32, 45, 52; *see also Carlson v. Boston Sci. Corp.*, 856 F.3d 320, 324 (4th Cir. 2017) (the Federal Rules "require parties to cite all evidence . . . at summary judgment"). Several of those

paragraphs concern disputed issues, including side effects relating to HIV (§ 3), the effects of stopping medication (§ 6), the risk of HIV transmission (§§ 7, 45, 52), and generally the rationality of aspects of military HIV policy (§§ 16-17, 19-20). These purported facts are not supported by material that can be presented as admissible evidence. Fed. R. Civ. P. 56(c)(2). Many of the purported facts are also immaterial. *See* PLUF §§ 1-2, 9, 11, 16-17, 19-20, 23, 29-36, 38, 41, 48-49, 53, 57. In addition, Defendants contradict the following paragraphs as follows:

1-2, 11. Plaintiffs make various allegations about a history of stigma and invidious discrimination against PLWH, but nowhere do Plaintiffs cite evidence that the accession policy was motivated by invidious discrimination, which Defendants would dispute.

3. ART regimens are associated with numerous side effects. *See* SUF § 35.

6. Stopping treatment can quickly lead to viral rebound, at which point an individual's risk of transmitting HIV to others increases, and there is also a risk that the HIV infection could develop resistance to the individual's ART regimen. SUF §§ 15-16, 28.

7, 45, 52. Blood-to-blood transmission routes, particularly in the circumstances of combat deployments, provide a substantial and meaningful risk of transmission of HIV, even for individuals with an undetectable viral load. *See, e.g.,* SUF §§ 24-25, 27-31, 33.

16-17. The military's HIV accession policy improves the health of the military force, reduces the risk of disease transmission, protects foreign relations, and conserves financial resources.

19-20. Due to the risks associated with HIV discussed herein, the military may rationally deny individuals with well-managed HIV from certain deployments. *See* SUF § 26.

31. Detailed cost estimates are found at SUF §§ 37-38 and Ciminera Decl. §§ 43-54.

37-66. Discovery is ongoing and Defendants reserve the right to contradict the facts listed in these paragraphs. *See* ECF No. 47, at 2 (setting briefing schedule for motion to dismiss).

LITIGATION AND PROCEDURAL BACKGROUND

The Court previously considered two lawsuits about policies relating to deployment, retention, and commissioning of PLWH (*Harrison v. Austin*, 18-cv-641; *Roe v. Austin*, 18-cv-1565). The Court entered judgment for plaintiffs and enjoined certain aspects of military policy relating to the challenged policies. *See Harrison* ECF No. 314; *Roe* ECF No. 328. The government initially appealed the Court's decisions in *Harrison* and *Roe*. While the appeals were pending, the Solicitor General informed Congress that the "DoD . . . modified the enjoined policies and adopted new policies," and "[g]iven those circumstances," the government "determined that an appeal is not warranted." Ex. 7, Section 530D Letter, at 2. The government later dismissed the appeals.

The complaint in this case was filed on November 10, 2022, ECF No. 1, and the government answered on February 17, 2023. The same day, the government moved to stay the case and informed the Court that the military had convened a working group and directed it to "provide a recommendation . . . concerning whether to amend DoD's accession policy, as it pertains to HIV-positive individuals seeking to join the military." ECF No. 37, ¶¶ 6, 8. The Court granted the stay through April 14, 2023. ECF No. 38. After the stay was lifted, the parties proposed a joint discovery plan in which the DoD informed the Court that the "working group has now submitted its recommendation to the Under Secretary of Defense for Personnel and Readiness," but that "DoD's policy process is . . . still ongoing." ECF No. 43, at 2. That policy process remains ongoing. Plaintiffs filed their motion for summary judgment on May 31, 2023. ECF No. 58 ("Pl. Mem.").

LEGAL STANDARDS

Summary judgment is appropriate when there is "no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). "A dispute is genuine if a reasonable jury could return a verdict for the nonmoving party," and "[a] fact is

material if it might affect the outcome of the suit under the governing law.” *Jacobs v. N.C. Admin. Off. of the Courts*, 780 F.3d 562, 568 (4th Cir. 2015) (citation omitted). A party must identify undisputed, material facts that are sufficient to show that a party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(a). “A party asserting that a fact cannot be or is genuinely disputed must support the assertion by . . . citing to particular parts of materials in the record,” such as depositions, declarations, and other materials. Fed. R. Civ. P. 56(c)(1)(A); *see* Loc. Civ. R. 56(B) (similar). “A party may object that the material cited to support or dispute a fact cannot be presented in a form that would be admissible in evidence.” Fed. R. Civ. P. 56(c)(2). The court has an “affirmative obligation . . . to prevent factually unsupported claims and defenses from proceeding to trial.” *Drewitt v. Pratt*, 999 F.2d 774, 778-79 (4th Cir. 1993) (quotation marks omitted).

Controlling Fourth Circuit precedent holds that equal protection claims challenging classifications based on HIV-status are subject to rational-basis review. *Doe v. Univ. of Md. Med. Sys. Corp.*, 50 F.3d 1261, 1267 (4th Cir. 1995). The military may therefore appropriately treat individuals diagnosed with HIV differently from those without HIV so long as the differential treatment is “rationally related to a legitimate state interest.” *Giarratano v. Johnson*, 521 F.3d 298, 303 (4th Cir. 2008). Under the rational basis standard, a defendant “‘need not actually articulate at any time the purpose or rationale supporting its classification,’ and it is not required to produce evidence showing the rationality of its classification.” *Pulte Home Corp. v. Montgomery Cty.*, 909 F.3d 685, 693 (4th Cir. 2018) (quoting *Heller*, 509 U.S. at 320). Defendants’ policies “[are] entitled to ‘a strong presumption of validity,’ and must be sustained if ‘there is any reasonably conceivable state of facts that could provide a rational basis for the classification.’” *Thomasson v. Perry*, 80 F.3d 915, 928 (4th Cir. 1996) (*en banc*) (quoting *Heller*, 509 U.S. at 318-20). Thus, “[t]he burden is on the one attacking the [government’s policy] to negative every conceivable basis which might

support it.” *Heller*, 509 U.S. at 320 (citation omitted). Classifications challenged under rational basis review are “not subject to courtroom factfinding and may be based on rational speculation unsupported by evidence or empirical data.” *Id.* (quoting *FCC v. Beach Commc’ns, Inc.*, 508 U.S. 307, 315 (1993)). “The test is not a subjective one . . . [and] the actual motivation for the [government’s] actions is irrelevant.” *Pulte Home Corp.*, 909 F.3d at 693 (cleaned up).

“[R]ational-basis [r]eview of an equal protection claim in the context of agency action is similar to that under the APA.” *Roe v. Shanahan*, 359 F. Supp. 3d 382, 411 (E.D. Va. 2019) (second alteration in original) (quoting *Cooper Hosp./Univ. Med. Ctr. v. Burwell*, 179 F. Supp. 3d 31, 47 (D.D.C. 2016)). “In such a case, the equal-protection argument is ‘folded into the APA argument, since no suspect class is involved and the only question is whether . . . the [defendants’ treatment] was rational (*i.e.*, not arbitrary and capricious).” *Cooper*, 179 F. Supp. 3d at 47 (quoting *Ursack, Inc. v. Sierra Interagency Black Bear Grp.*, 639 F.3d 949, 955 (9th Cir. 2011)).

ARGUMENT

I. Plaintiffs’ Motion Should Be Denied For Lack of Evidence

In this brief, Defendants identify several ways in which the policy is rationally related to legitimate military interests, including the establishment and maintenance of a healthy military force, preserving financial resources, and maintaining relationships with foreign partners. Plaintiffs have failed to meet their burden to negate each of those rational bases, as well as any other conceivable rational basis, *see Heller*, 509 U.S. at 320, much less introduce any record evidence contradicting those bases. Instead, Plaintiffs cite only the Court’s previous ruling in *Harrison* and the Fourth Circuit’s ruling on the preliminary injunction in *Roe*, neither of which concerned original accession, in an attempt to contradict those rational bases. Pl. Mem. at 22-23; *see, e.g.*, PLUF ¶¶ 3, 6-7, 16-17, 19-20, 45, 52 (each citing only to previous decisions in *Harrison* and *Roe*).

Thus, rather than citing evidence on these fact-intensive topics, Plaintiffs rely exclusively on a theory that the decisions in *Harrison* and *Roe* preclude the government from arguing that the accession policy is rationally related to the cited interests. *See* Pl. Mem. at 21. But this is a different case, with different plaintiffs, challenging different policies, and no preclusion theory is applicable.

Plaintiffs cite this Court's previous statements about the "law of the case" doctrine. *Id.* at 22. Defendants recognize that the Court, in its order on an enlargement motion, stated "a significant amount of the scientific and medical issues have been resolved and are the law of the case," ECF No. 64. Respectfully, however, the law-of-the-case doctrine is inapplicable, as it applies only to proceedings in the same case. *See Graves v. Lioi*, 930 F.3d 307, 318 (4th Cir. 2019) ("The law-of-the-case doctrine recognizes that 'when a court decides upon a rule of law, that decision should continue to govern the same issues in subsequent stages in the same case.'" (quoting *Arizona v. California*, 460 U.S. 605, 618 (1983))); *Wright & Miller*, Fed. Prac. & Proc. § 4478 ("Law-of-the-case rules . . . do not apply between separate actions, even if they are related.").

Nor can Plaintiffs rely on a theory of collateral estoppel. "[T]he United States may not be collaterally estopped on an issue . . . adjudicated against it in an earlier lawsuit brought by a different party." *United States v. Mendoza*, 464 U.S. 154, 155 (1984); *accord CASA de Md. v. Trump*, 971 F.3d 220, 261 (4th Cir.), *vacated upon grant of reh'g en banc*, 981 F.3d 311 (4th Cir. 2020). Accordingly, Plaintiffs may not rely on *Harrison* and *Roe*, under any preclusion theory, to foreclose the government from justifying the HIV-accession policy based on any rational basis. Plaintiffs instead have the burden to negate every conceivable rational basis by pointing to admissible evidence. Because Plaintiffs have cited no record evidence on contested issues (including the possibility of transmission during deployments, the possibility of viral rebound, other health effects, and foreign relations concerns), their motion must be denied for a complete failure of proof.

II. The Military’s Medical Standard Concerning the Accession of Those With HIV Is Rationally Related to Promoting the Health or Readiness of the Armed Services

“In the equal-protection context, a ‘challenged classification need only be rationally related to a legitimate state interest unless it violates a fundamental right or is drawn upon a suspect classification such as race, religion, or gender.’” *Ameur v. Gates*, 759 F.3d 317, 327 (4th Cir. 2014) (quoting *Giarratano*, 521 F.3d at 303). Because accession standards classify individuals based on medical conditions, rather than any suspect class, those standards are subject to rational-basis review. And it is a plainly legitimate goal for the military to seek to have its incoming recruits be as healthy as possible. Accordingly, any medical standard that sets minimum health requirements for incoming recruits is rationally related to that legitimate goal and, consequently, is constitutional.

Moreover, the question of *where* the military chooses to draw lines in its medical standards – that is, which conditions are disqualifying for accession, and which are not, and which conditions are acceptable for retention purposes but not for accession – is not subject to second-guessing in litigation. *See Beach Commc’ns*, 508 U.S. at 316 (“Defining the class of persons subject to a regulatory requirement . . . inevitably requires that some persons who have an almost equally strong claim to favored treatment be placed on different sides of the line, and the fact that the line might have been drawn differently at some points is a matter for legislative, rather than judicial, consideration.” (cleaned up)). Thus, the military’s decision to impose stricter conditions for one medical condition has no bearing on another accession standard’s constitutionality. *See, e.g., Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 489 (1955) (“The legislature may select one phase of one field and apply a remedy there, neglecting the others.”). Because the military is not required to “address its problems wholesale,” but instead is “free to regulate by degree, one step at a time,” *Helton v. Hunt*, 330 F.3d 242, 246 (4th Cir. 2003), the military may constitutionally impose accession restrictions relating to HIV but not other diseases, and likewise it may also impose strict

impositions on HIV at the accession stage even if it has more relaxed requirements relating to deployment, commissioning, and retention of current members.

Furthermore, any medical requirement set by the military is entitled to substantial deference. As the Supreme Court has long recognized, the “complex subtle, and professional decisions as to the composition . . . of a military force are essentially professional military judgments.” *Giligan v. Morgan*, 413 U.S. 1, 10 (1973). “[J]udicial deference . . . is at its apogee when legislative action under the congressional authority to raise and support armies . . . is challenged.” *Rostker v. Goldberg*, 453 U.S. 57, 70 (1981); *see also Orloff v. Willoughby*, 345 U.S. 83, 92 (1953).

III. The Accession Policy Is Rational Because of Medical Risks Associated With HIV

The HIV accession policy is rationally related to several medical risks. First, individuals with HIV may not sufficiently take their daily medication, which would result in their viral load rising. Second, HIV is an infectious, incurable, bloodborne disease, and there are several possible routes in which the disease could be transmitted to other service members on the battlefield. And third, HIV is also associated with various comorbidities and side effects that could harm a service member’s health. By restricting the accession of PLWH, the military reduces the pool of individuals who present each of these risks and thereby protects the health of the military force.

A. Risk of Non-Adherence to Medication

A fundamental characteristic of HIV is that PLWH must take medication every day to keep their infection well-controlled. Otherwise, viral load will increase, posing the risk of health consequences for the HIV-positive person and increasing the risk of transmission. SUF ¶¶ 14-16, 28. Presumably for those reasons, Plaintiffs ask the Court to enjoin the accession policy only for individuals who are virally suppressed. Compl., Prayer for Relief ¶ C. However, even if an individual seeking to join the military is *currently* virally suppressed, there is no guarantee that individual

will *remain* virally suppressed through his or her military service. Should the individual ever stop properly adhering to their medication, his or her viral load will cease to be well-controlled. SUF ¶ 15. The CDC recognizes that long-term adherence to medication cannot be presumed, even for someone who currently has attained viral suppression. Ex. 15, *HHS ART Guidelines*, at L-2 (“It is also important to realize that retention and adherence are not static states. . . . [A]dherence is a complex behavior[.]”). Those concerns may be particularly acute for the military, as the rigors of deployment could make adherence to ART medication less likely. SUF ¶ 19; *see infra*. Accordingly, the military properly considered the possibility that an individual might not remain virally suppressed during military service. Ciminera Decl. ¶ 25.

These concerns are not speculative. Approximately one-third of the PLWH in the United States are not virally suppressed, and one medical study found that only approximately 85% of individuals receiving ART medication at a clinic were properly adherent. SUF ¶ 17. While a military study considering data between 2012 and 2018 found that PLWH currently in the military had uncommonly high rates of adherence, with almost all individuals in the study achieving viral suppression, none of the PLWH in the study were deployed. Blaylock Decl. ¶ 23. It is therefore rational for the military to decline to accept individuals into military service when those individuals pose a known risk of a potentially worsening infectious disease that could limit their deployability.

B. Risk of Infection

Current medical standards recognize that several blood-to-blood transmission routes pose a meaningful medical risk of infection, even for individuals with an undetectable viral load. SUF ¶¶ 23, 29, 31. Restricting the ability of individuals with HIV to enlist in the military is thus rationally related to the goal of ensuring that safe blood supplies are available for use in combat medical care and preventing the spread of communicable diseases on the battlefield.

1. Viral Rebound

Plaintiffs claim that virally suppressed PLWH pose a negligible risk of infecting others. Pl. Mem. at 22-23. Defendants dispute that contention, but it also rests on the faulty assumption that PLWH on deployments will be able to easily maintain viral suppression. It is not definitively known what level of adherence is necessary to maintain viral suppression, but medical authorities make clear that strict adherence is required, and some studies characterize individuals as “adherent” only if they take 95% of their daily medication, SUF ¶¶ 14, 16, a level that might be difficult to maintain given the stress and exigencies of deployments, *id.* ¶¶ 19-20. Deployments may involve constant movement, lack of sleep, high stress, irregular daily activities, and operations away from base in which a service member might not carry extra medication, all of which could contribute to a lower likelihood of maintaining strict adherence. *Id.* ¶ 19.

In addition, deployments also present the risk that medication might be lost or destroyed. SUF ¶ 20. If that that occurs, viral rebound could occur quickly: U.S. medical authorities note that “[v]iral rebound typically occurs within days to weeks after ART cessation and has been observed as early as 3 to 6 days after stopping treatment.” *Id.* ¶ 15. If an individual’s medication is lost or destroyed during a deployment, the military may not be able to re-supply that medication promptly, especially if the service member is in a combat environment, and these concerns could be more acute in potential future scenarios, particularly involving near-peer conflicts. *Id.* ¶ 20.

2. Blood Transfusions

If an HIV-negative person receives a blood transfusion with HIV-infected blood, the CDC has estimated the likelihood of transmission is 92.5%. SUF ¶ 18. If the donor has an undetectable viral load, the precise level of risk of infection is unknown, but it remains substantial. *Id.* Accordingly, the FDA recommends that PLWH should not donate blood. *Id.* ¶ 23.

Ensuring that blood supplies are available and safe on the battlefield is a plainly legitimate military interest. And an important resource the military uses to provide blood in life-saving circumstances is the walking blood bank, in which donors near the point of treatment provide blood for almost-immediate transfusion. SUF ¶ 22. While the military only resorts to the walking blood bank in emergency situations when other stored blood supplies are unavailable, those situations do arise. *Id.* The military conducted more than 6,000 walking blood bank transfusions in Iraq and Afghanistan, and military models suggest that a hypothetical future conflict with a near-peer adversary would require substantially greater reliance on the walking blood bank. *Id.* ¶ 25.

By retaining HIV status as a disqualifying condition for enlistment, military accession policy helps ensure the availability of safe blood supplies. While the military imposes various protections to try to prevent the transmission of bloodborne illnesses through the walking blood bank, SUF ¶ 23, the risk of possible transmission cannot be eliminated. Although PLWH are told not to donate blood, the military assesses that there is a risk that, despite those orders, PLWH may nonetheless donate blood in emergency situations. *Id.* ¶ 24. In the stress of those situations, the service member may forget about the order, misunderstand it, or simply ignore it in order to provide blood to a fellow soldier facing a life-threatening loss of blood. *Id.* These concerns are not merely speculative: the military is aware of at least one documented instance in which a service member knew he had a bloodborne illness but donated anyway, leading to the transmission of hepatitis C. *Id.* In battlefield transfusion situations, the military cannot guarantee that fresh blood is free from all infectious agents. Rapid HIV tests are normally only available at certain higher-level medical facilities in part because of storage requirements. *Id.* ¶ 23 Even when a rapid test is available there may not be time to await the results of the test (possibly twenty minutes or longer) before a transfusion is required. *Id.* While it is impossible to precisely quantify the risk that HIV-positive service

members pose to the walking blood bank, the military has determined that the risk is meaningful, which is precisely the type of predictive judgment for which the military should be granted substantial deference. *See Trump v. Hawaii*, 138 S. Ct. 2392, 2421 (2018) (courts should defer to the “Executive’s predictive judgments” on matters relating to national security).

Even if it were possible to guarantee that PLWH would never donate blood, the military’s HIV accession policy would still advance the goal of ensuring adequate blood supplies. Because PLWH are permanently barred from donating blood means, they would not be able to contribute to a walking blood bank if one were required. Particularly if an individual with HIV were part of a small unit, the inability to donate blood would increase the risk to the entire unit. SUF ¶ 25. And given the possibility of substantially greater reliance on the walking blood bank in future conflicts, this problem could become even more acute. *Id.* Although the DoD must accept and account for a limited number of these possible situations under the revised deployment policy, it is rational for the DoD not to take on an increased amount of guaranteed risk by barring the accession of PLWH.

3. Combat Medical Care

Providing or receiving medical care in combat provides another route of potential HIV infection. Injuries incurred in battle often involve severe trauma and large volumes of blood, providing a possible route of blood-to-blood infection that the military must consider. SUF ¶ 30.

In the *Harrison* and *Roe* cases, the Court previously considered the risk of HIV transmission presented by combat medical care and held that those risks were not sufficient to justify a categorical ban on deployment. *Harrison v. Austin*, 597 F. Supp. 3d 884, 910-11 (E.D. Va. 2022). In so holding, the Court primarily relied on the Fourth Circuit’s opinion affirming the preliminary injunction in *Roe*, in which the court of appeals in turn relied on the fact that the estimated per-act transmission risk of a percutaneous injury was approximately 0.23%. *See Harrison*, 597 F. Supp.

3d at 910-11; *Roe v. DoD*, 947 F.3d 207, 227 (4th Cir. 2020). However, the Fourth Circuit emphasized that its opinion on the preliminary injunction was based on a “limited record” at a “preliminary stage.” *Roe*, 947 F.3d at 222, 224. The Fourth Circuit did not have before it evidence that could appropriately contextualize the estimated risk of transmission through a percutaneous injury.

Although a 0.23% per-act exposure risk may appear trivial to a lay observer, medical authorities consider that to be a meaningful risk for which efforts should be made to prevent its occurrence, and if it does occur, then medical intervention is necessary. SUF ¶ 29. The CDC states that an “occupational exposures to HIV,” such as punctures from a needle containing HIV-infected blood, “should be considered urgent medical concerns and treated immediately.” *Id.* In other guidance, the CDC characterized a “percutaneous contact” with HIV-infected blood as representing a “substantial risk for HIV acquisition.” *Id.* Likewise, the New York Department of Health states that “[a]n HIV exposure is a medical emergency,” and classifies “penetrating” injuries such as needlesticks as a “higher-risk HIV exposure” that require prompt medical intervention. *Id.*

Indeed, the Fourth Circuit has squarely held that the possibility of HIV transmission was a “significant risk” during medical care, even in the civilian context, which justified a hospital in prohibiting a surgeon living with HIV from conducting surgical procedures that had a high likelihood of percutaneous injuries. *Doe*, 50 F.3d at 1262, 1266. *Doe* involved a surgeon who suffered a needlestick while treating a patient who may have been infected with HIV, and the surgeon later tested positive for HIV. *Id.* at 1262. After the hospital employing the surgeon restricted him from surgical practice and eventually fired him, the surgeon sued, arguing that “the risk that he will transmit HIV to one of his patients is so infinitesimal that it cannot, regardless of the degree of harm involved, be considered a significant risk.” *Id.* at 1266. The Fourth Circuit rejected that argument. Even though the court of appeals recognized that “there is general agreement among

public health officials that the risk is small,” *id.* at 1263, it nonetheless “h[eld] that Dr. Doe does pose a significant risk to the health and safety of his patients that cannot be eliminated by reasonable accommodation.” *Id.* at 1266. The Fourth Circuit held that there would still be a substantial risk of infection even if the surgeon were to take “extra precautions,” including “wearing two pairs of gloves, making stitches with only one hand, and using blunt-tipped, solid-bore needles.” *Id.*

Medical authorities recommend that if someone has a percutaneous injury involving HIV-infected blood, then that person should promptly begin a four-week PEP regimen, notwithstanding the estimated 0.23% transmission risk. SUF ¶ 31. PEP is still recommended even when the source of the blood has an undetectable viral load. *Id.* Furthermore, the risk of infection is not the only relevant harm to consider. If PEP is indicated, additional medical follow-up is necessary. *Id.* ¶ 32. After PEP is prescribed, there should be initial baseline testing, followed by HIV viral load monitoring for several months after exposure. *Id.* If an individual were prescribed PEP after a percutaneous exposure to HIV-infected blood, the military would likely attempt to evacuate that individual. *Id.* Thus, even though the likelihood of actual HIV *transmission* in those circumstances were relatively low, the likelihood of needing to *remove* someone from deployment would be very high. That approach accords with the CDC’s analogous recommendations in civilian healthcare. *See Ex. 18, Occupational Exposure Guidelines*, at 21 (recommending that “a surgeon who sustains an occupational exposure to HIV while performing a surgical procedure should promptly scrub out of the surgical case, if possible, and seek immediate medical evaluation for the injury and PEP”). Any unnecessary evacuation from combat represents an obvious harm to the military. And if the person needing evacuation were a combat surgeon – a relatively likely person to be prone to percutaneous injuries while giving care if an HIV-positive service member were injured – evacuating that individual could limit the availability of medical care to the rest of the unit. SUF ¶ 32.

In any event, the CDC’s estimate of a 0.23% transmission risk from a percutaneous injury likely understates the risk of transmission in combat medical care. *See* SUF ¶ 30. CDC guidance notes that the risk of a percutaneous injury resulting in HIV transmission is likely increased by larger volumes of blood, deep injuries, and higher viral loads. *Id.* ¶ 28. Combat medical care involves much larger volumes of blood than would be seen in typical civilian trauma cases. *Id.* ¶ 30. Combat wounds may be full of jagged shrapnel or sharp bones, increasing the risk that a caregiver will cut his or her hands when attempting to treat the wound, thereby providing direct routes for blood-to-blood transmission. *Id.* Moreover, particularly when care is rendered close to the front line (such as by a combat medic or non-medical fellow soldier providing care immediately after the injury was incurred), that individual may also be wounded or have non-intact skin as a result of the combat conditions and thus also have several routes of possible bloodborne transmission. *Id.* In addition, protective measures such as the use of protective gloves and the ability to wash out cuts on the caregiver may not be available, unlike at a civilian hospital. *Id.* Finally, the nature of a combat deployment may make it more likely that PLWH could experience viral rebound.

In short, combat medical care presents a substantial risk of HIV transmission. While the precise risk is unquantifiable, it is higher than the risk posed by the mine run of “needlestick”-like injuries in the civilian world. SUF ¶ 30. Given that civilian medical authorities conclude that even a 0.23% chance of risk of transmission constitutes a “medical emergency” and “urgent medical concern” that requires prompt medical attention, *id.* ¶¶ 28-29, it is rational for the military to attempt to minimize the instances in which an even higher risk of transmission is presented. And even though the risk of actual transmission may still be low in absolute terms, the fact that an individual who is prescribed PEP after being exposed to infected blood would need to be evacuated from the battlefield is another reason underscoring the rationality of military accession policy.

4. Explosive Injuries

Another potential route of HIV transmission in the military context involves the possibility of infected blood being exploded directly into the body of another person. SUF ¶ 33. The CDC has recognized the possibility of this type of transmission, based in part on studies that detected the presence of bloodborne pathogens in bone shards that had implanted into a survivor of a suicide bombing, and the agency recommends PEP after an exposure to HIV-infected blood. *Id.*

5. Infection Risks Remain Relevant Despite Recent Changes to Deployment Policies

Until recently, the military placed substantial limitations on the ability of PLWH from participating in deployments, including effectively prohibiting deployments to the Central Command. *See Harrison*, 597 F. Supp. 3d at 898. However, recently amended deployment policies state that “[c]overed personnel are not non-deployable solely for the reasons that they are HIV-positive,” and that “[d]ecisions on the deployability of covered personnel will be made on a case-by-case basis.” Ex. 6, June 6 Mem., at 2. Thus, consistent with the Court’s prior injunctions, the military imposes no categorical bar to the deployment of PLWH. *See Harrison* ECF No. 314 (amended order). Since that policy change, the military has allowed PLWH to deploy, including to Central Command. SUF ¶ 43.

The possibility of HIV transmission on the battlefield nonetheless remains a meaningful risk. And the fact that the military does not categorically deny current service members from deploying does not mean that these potential risks must be ignored when deciding whether to allow *new* enlistments of individuals who have an incurable disease that presents risks of future infection. *See* SUF ¶ 1; *Helton*, 330 F.3d at 246 (allowing “regulat[ion] by degree, one step at a time”).

Even though the military does not *categorically* disallow individuals from deploying, it is possible that a *particular* deployment might present circumstances in which PLWH should not

deploy. SUF ¶ 26. For example, it might be improper for PLWH to deploy as part of a small unit where it was important that every member of the unit be able to donate blood. *See id.* ¶ 25. It is impossible to determine all possible future deployment scenarios, but it is certainly plausible that there might be some in which PLWH would not be allowed to deploy. This is a relevant consideration at the accession stage, where one of the key criteria in the military's accession medical standards is to ensure that new recruits are able to deploy *anywhere*. *See* SUF ¶ 2.

But even if a potential recruit living with HIV would not ever be denied a specific deployment in the future, it still would be rational for the military to deny accession based on the possibility of transmission. Because combat deployments present several possible risks of HIV transmission, even if currently serving PLWH are allowed to deploy, by restricting the entry of *new* PLWH, the total pool of possible deployers who present risks of HIV infection is decreased. Similarly, because PLWH are not eligible to donate blood, the current accession policy limits the pool of individuals who might deploy in the future but would not be able to contribute to that lifesaving procedure. In short, even though the military has accepted some risks by allowing current service members with HIV to deploy, it is not irrational for the military to attempt to reduce those risks by restricting the accession of PLWH. That is a particularly reasonable distinction given that the military has already invested a substantial amount of training and other resources into current service members but not new recruits. It is not irrational to consider that substantial investment in current service members in conducting its risk-tolerance determination. *See* SUF ¶ 1; Ciminera Decl. ¶ 7.

C. Side Effects and Co-Morbidities Associated with HIV and ART Medication

PLWH are more likely to suffer from various comorbidities and side effects compared to the uninfected population. SUF ¶¶ 34-35. They are more likely to have heart attacks, liver disease, renal disease, peripheral vascular disease, and certain cancers. *Id.* ¶ 34. In addition, common ART

medications are associated with bone mineral density loss, renal dysfunction, increased lipid profiles, and weight gain. *Id.* ¶ 35. Mild neurocognitive impairment is also a concern. *Id.* These side effects and comorbidities can occur in virally suppressed patients and may not occur until years after HIV treatment begins, *id.* ¶ 36, and so they may not be apparent during the accession process. Moreover, some of the conditions that are common to military training and deployments – such as dehydration, lack of sleep, lack of regular meals, and disruptions in medication – can aggravate the side effects of infections, and the same could be true of HIV. *Id.*

In short, individuals with HIV are relatively likely to have various illnesses or other negative health conditions and restricting the ability of individuals with HIV to join the military is therefore rationally related to the goal of ensuring a healthy military. For example, the military infectious disease community has noted concerns that weight gain – a common side effect of ART medication – could make it harder to maintain military physical standards. SUF ¶ 35.

IV. The Accession Policy Is Rational Because HIV-Status Imposes Disproportionate Costs on the Military Healthcare System

PLWH would impose disproportionately higher financial costs on the military compared to individuals without HIV. On a per-person basis, medical costs associated with PLWH are six-fold greater than for persons without HIV. SUF ¶ 37. Counting those and other costs, the military estimates that allowing the accession of PLWH would cost approximately \$153,000 more per person per year as compared to HIV-negative service members. *Id.* ¶ 38. It is therefore rational to exclude HIV-positive candidates to further the military's interest in conserving financial resources.

Courts repeatedly have affirmed that conserving financial resources is a legitimate interest. *See, e.g., Armour v. City of Indianapolis*, 566 U.S. 673, 682-84 (2012); *Schweiker v. Wilson*, 450 U.S. 221, 238-39 (1981); *Dandridge v. Williams*, 397 U.S. 471, 483-86 (1970); *Park Shuttle N Fly, Inc. v. Norfolk Airport Auth.*, 352 F. Supp. 2d 688, 699-700 (E.D. Va. 2004). Even

Massachusetts v. HHS, one of the lead cases cited by Plaintiffs, acknowledges that budgetary concerns will defeat an equal-protection challenge under rational-basis review. *See* 682 F.3d 1, 9-11 (1st Cir. 2012) (holding that under “classic rational basis review,” plaintiffs challenging the Defense of Marriage Act on equal-protection grounds “cannot prevail” because “Congress could rationally have believed that DOMA would reduce costs,” but striking down DOMA under “intensified scrutiny” involving “a more careful assessment of the justifications than the light scrutiny offered by conventional rational basis review”).

In *Harrison* and *Roe*, the Court did “not take[] lightly” “the increased burden of caring for an HIV-positive patient,” but instead concluded that “th[e] concern d[id] not apply”: the plaintiff “ha[d] already enlisted and therefore his medical costs [we]re not ‘additional’ costs.” 597 F. Supp. 3d at 913-14. So although the Court held that the “cost-based justification . . . [wa]s not rational as applied to” the plaintiff, it acknowledged that “th[e] concern of ‘additional costs’ may apply” in a case like this one involving “HIV-positive individuals who wish to enlist.” *Id.* at 914.

Plaintiffs do not contest that the accession policy conserves resources; instead, they argue that because of DoD’s large budget, the Court should not consider the cost of changing the policy, which is estimated at approximately \$13.63 million per year. But that number remains significant in absolute terms, and on a per-person basis, HIV-positive service members impose substantially greater costs than would service members without HIV. *See* SUF ¶ 38. Whether those costs are significant should be left to the discretion of the military. *See McArthur v. Braband*, 610 F. Supp. 3d 822, 838 (E.D. Va. 2022) (the judiciary may not “sit as a super[budgeteer] to judge the wisdom or desirability of” policy tradeoffs) (quoting *Wilkins v. Gaddy*, 734 F.3d 344, 348 (4th Cir. 2013)).²

² For similar reasons, the Court should reject Plaintiffs’ argument that because the DoD allows transgender individuals or individuals with chronic conditions to join the military despite medical costs, the DoD must also allow HIV-positive individuals to join the military despite their

Moreover, military judgments that a policy “consumes the resources of the military to a degree . . . beyond what is warranted” merit significant deference. *Middendorf v. Henry*, 425 U.S. 25, 45 (1976); *see also Gilligan*, 413 U.S. at 10 (noting courts lack of competence military affairs). Such decisions “are essentially professional military judgments, subject always to civilian control of the Legislative and Executive Branches.” *Id.* (emphasis removed). Accordingly, Plaintiffs miss the point when they argue (at 26-27 & n.5) that “the net savings to the government” from excluding HIV-positive candidates from the military may be “minimal” because the government “would likely” end up paying for the individuals’ HIV care: the question is not whether the government as a whole will incur a cost, but rather whether denying accession to PLWH rationally advances the DoD’s and Army’s interest in protecting their finite resources.

Likewise, Plaintiffs are incorrect to argue (at 26) that “any health care costs must be weighed against the benefits of gaining the service and commitment of people . . . eager to dedicate themselves to the protection of the United States.” That turns rational-basis review on its head: “the only requirement” for rational-basis review “is that [the policy] be rationally related to a legitimate governmental interest.” *Harris v. McRae*, 448 U.S. 297, 326 (1980). “It is not the mission of this Court or any other” to “independent[ly] apprais[e] . . . the competing interests involved” in a challenged policy or “to decide whether the balance of [those] competing interests . . . is wise social policy.” *Id.*; *see also Lee Optical*, 348 U.S. at 488.

What is more, Plaintiffs’ cases are inapposite because the cases rejected cost-savings arguments based on a lack of record evidence. Take *Plyler v. Doe*, where the Supreme Court struck

increased medical costs. That argument is inconsistent with rational-basis review. *See, e.g., Helton*, 330 F.3d at 246 (the government need not “address its problems wholesale” and may “regulate by degree, one step at a time”); *Beach Commc’ns*, 508 U.S. at 316 (courts must “allow[] leeway to approach a perceived problem incrementally”).

down a Texas law denying public schooling for unlawfully present noncitizens. *See* 457 U.S. 202 (1982). Contrary to Plaintiffs' argument (at 23), *Plyler* does not forbid drawing policy lines based on financial burdens. Rather, the Court rejected Texas's asserted concerns about financial burdens because "[t]here [wa]s no evidence in the record" supporting them. *Id.* at 228-30. So too for *Diaz v. Brewer*, when the Ninth Circuit rejected Arizona's attempt to exclude same-sex partners from state-employee health-care benefits based on financial concerns because Arizona had "not provided any [supporting] evidence." 656 F.3d 1008, 1013 (9th Cir. 2011); *see also Bassett v. Snyder*, 59 F. Supp. 3d 837, 851-52 (E.D. Mich. 2014) (concluding that Michigan relying on financial costs to restrict domestic-partner eligibility for state-health benefits was a pretext for gay animus because Michigan's "rationalization based on saving money [wa]s nothing more than a Potemkin Village; there is no substance backing up its reasoning"). Here, as discussed above, there is significant evidence concerning the costs associated with HIV-positive service members.

Plaintiffs are essentially asking for some form of heightened rational-basis scrutiny paralleling what the Supreme Court applied in *Plyler* or what the First Circuit applied in *Massachusetts*. In *Massachusetts*, the Court applied an "intensified" rational-basis review, both because the challenged law "intrude[d] broadly into an area of traditional state regulation" and because it would threaten "the main components of the social safety net" for people that "ha[d] long been the subject of discrimination," 682 F.3d at 7-8, 11-13, neither of which are true here. As for *Plyler*, that case appeared to apply what some call "rational basis with bite," largely because the challenged Texas law disfavored noncitizens who could not protect themselves through the political process. *Halgren v. City of Naperville*, 577 F. Supp. 3d 700, 752 (N.D. Ill. 2021); *see Plyler*, 457 U.S. at 216 n.14. But the Supreme Court expressly declined to extend that approach beyond the "unique circumstances" of *Plyler*. *See Kadrmas v. Dickinson Pub. Schs.*, 487 U.S. 450, 459-60 (1988). As

discussed below, Fourth Circuit precedent makes clear that classifications based on HIV are subject to rational basis review, and Plaintiffs cite no Fourth Circuit case applying any non-traditional form of rational basis review, let alone any case (from any court) using non-traditional rational basis review to probe a military resource allocation, when judicial deference “is at its apogee,” *Rostker*, 453 U.S. at 70; *see Thomasson*, 80 F.3d at 928. The Court should decline to be the first.

V. The Accession Policy Is Rational Because of Foreign Relations Concerns

Defendants also have a legitimate, and indeed compelling, interest in preserving their relationships with the foreign countries in which the Military Services currently have or in the future may establish a physical presence (“host nations”). As explained below, certain host nations, specifically in the U.S. Central Command’s area of operations (“CENTCOM AOR”), do not permit the entry or presence of HIV-positive foreign nationals. Defendants generally would not deploy service members with HIV to those host nations, both to preserve international relationships and to protect those service members. This deployment limitation applies independent of medical considerations for HIV-positive service members, and it is rational for the military to deny the accession of individuals who are not worldwide deployable. *See DoDI 6130.03*, § 1.2(d)(4).

In most cases, the DoD is present in a host nation only by consent or invitation. *SUF* ¶ 39. To the extent possible, in consideration of this permissive presence and diplomatic norms, the DoD respects the laws and customs of host nations. *Id.* ¶ 40. While DoD may not be bound to comply with the host nation laws, to protect diplomatic relationships for both the military and civilian interests of the United States, the DoD sometimes requires individuals present in host nations under its auspices to follow local laws. *See id.* Specifically, the DoD sometimes imposes restrictions on its personnel that align with the laws and customs of host nations. *Id.*

This practice is long-standing and applies broadly beyond the specific circumstance of HIV entry restrictions. The DoD acknowledges that host nation laws “may prohibit or restrict various activities generally permissible in Western societies” but nevertheless imposes those rules because it has determined that “[r]espect for restrictions on such activities is essential to preserve amicable relations between the United States and host nations” and prudent “to maintain good order and discipline and ensure optimal force readiness.” Huntsinger Decl. ¶ 6 (quoting *id.*, Ex. A Central Command General Order Number 1D (2020), ¶ 1); *see* SUF ¶ 40.

The DoD restricts the deployment of PLWH to certain host nations within the CENTCOM AOR for the same reasons. While some countries within the AOR have no restrictions on the entry or presence of HIV-positive individuals, and others have limitations which do not rise to the level of impacting the entry of those service members with HIV, still others fully prohibit the entry of foreign nationals with HIV or explicitly state that such individuals will be deported if discovered in country. SUF ¶¶ 41, 43. Although CENTCOM policy previously disqualified all HIV-positive personnel from deployment to the AOR, its regulations nevertheless have long noted that “some nations within the CENTCOM AOR have legal prohibitions against entering their country(ies) with this diagnosis,” and that “CENTCOM waiver cannot override host or transit nation infectious disease or immunization restrictions.” Huntsinger Decl. Ex. C, USCENTCOM Individual Protection and Individual Unit Deployment Policy, MOD-13, Tab A ¶7(C)(2); ¶7(C)(5); *see* SUF ¶ 41.

Under current Central Command policy implementing the Secretary of Defense’s June 6, 2022 Memo, HIV-positive status is no longer disqualifying for deployment to the AOR. SUF ¶ 42. Because of that change, Central Command policy now specifically directs the evaluation of host nation laws related to HIV entry before the approval of deployment within the AOR for HIV-positive personnel. *Id.*; Huntsinger Decl., Ex. D, Individual Protection and Individual Unit

Deployment Policy (“MOD-17”) (2023), ¶15.G.1 (HIV-positive personnel “may be denied entry to the AOR secondary to host nation prohibitions regarding HIV.”); *id.* MOD-17, Tab A ¶7(C)(2) (HIV-positive personnel “that are asymptomatic with undetectable viral load may deploy dependent on host nation requirements.”). The DoD does not limit the deployment of HIV-positive personnel on this basis to other host nations within the AOR whose laws do not explicitly prohibit the entry or presence of HIV-positive foreign nationals. Since the policy change on June 6, 2022, Central Command has both approved deployment waivers for covered HIV personnel and denied several waivers for deployments to host nations that bar HIV-positive foreign nationals. SUF ¶ 43.

The DoD’s policy with regard to host nation HIV entry requirements is a matter of foreign relations. It is unrelated to any disputes about the state of medical science and is driven by operational necessity and the policies of other nations. “[P]olicies in regard to the conduct of foreign relations [and] the war power . . . are so exclusively entrusted to the political branches of government as to be largely immune from judicial inquiry and interference.” *Mathews v. Diaz*, 426 U.S. 67, 81 n.17 (1976) (quoting *Harisiades v. Shaughnessy*, 342 U.S. 580, 588-89 (1952)); *see also*, *e.g.*, *Hawaii*, 138 S. Ct. at 2418-19 (quoting *Mathews*, 426 U.S. at 81) (decisions that “may implicate ‘relations with foreign powers’ . . . ‘are frequently of a character more appropriate to either the Legislature or the Executive.’” (quoting *Mathews*, 426 U.S. at 81)). The DoD has made the determination that for the preservation of necessary foreign relationships, HIV-positive personnel should generally not deploy to a host nation in direct contravention of that nation’s laws. Because of the DoD’s interests in respecting host nation laws and in maintaining a ready force of warfighters with unrestricted deployability, *see* SUF ¶ 2, it is rational to deny the accession of an individual for whom the military knows will not be worldwide deployable. While the DoD may accommodate the small number of individuals who are retained in the military after contracting HIV, it is rational

not to accept the additional risks and logistical complications inherent in accessing more individuals who are guaranteed to present these issues because they are already HIV-positive.

The HIV accession policy “must be afforded ‘a strong presumption of validity’ and ‘those attacking the rationality of the [policy] have the burden to negative *every conceivable basis* which might support it.’” *Int’l Refugee Assistance Project v. Trump (“IRAP”)*, 961 F.3d 635, 651 (4th Cir. 2020) (quoting *Beach Commc’ns*, 508 U.S. at 314-15). Thus, entirely apart from any other considerations put forward, Plaintiffs must demonstrate “that it is impossible to discern a relationship between” the accession policy and “legitimate state interests” concerning foreign relations and force readiness. *Id.* (quoting *Hawaii*, 138 S. Ct. at 2420-21). To prevail, Plaintiffs must demonstrate that the accession policy is “inexplicable by anything but animus,” *id.*, and for the reasons stated above, on the basis of long-standing foreign relations concerns alone, they cannot make that showing. In service of these critical foreign relations concerns, the DoD has imposed and continues to impose various restrictions drawn from host nation laws and customs on DoD personnel. Plaintiffs’ constitutional claims “must fail” if the accession policy “is even plausibly related” to a possible stated motivation “independent of unconstitutional grounds.” *Id.* (quoting *Hawaii*, 138 S. Ct. at 2420). The DoD’s respect for host nation HIV-entry restrictions is itself sufficient to satisfy this standard and show a rational relationship to a legitimate state interest—and especially when considered alongside the other rational bases for the policy discussed elsewhere in this memorandum.

VI. Regulations Based on HIV-Status Are Subject to Rational Basis Review

Plaintiffs contend, to “preserve the issue,” that HIV-based classifications should be subject to heightened scrutiny. Pl. Mem. at 28-29. Controlling precedent holds otherwise: the Fourth Circuit has made clear that constitutional claims challenging HIV-based classifications are subject to rational-basis review. *Doe*, 50 F.3d at 1267. Plaintiffs assert that *Doe* involved “since-amended

applicable statutory law,” Pl. Mem. at 29, but the relevant portion of that opinion dealt explicitly with the Equal Protection Clause and was unequivocal that “[c]lassifications involving individuals with disabilities are subject to rational basis scrutiny,” and applied that level of review to his HIV-based classification, *see Doe*, 50 F.3d at 1267; *see also id.* at 1262 n.2. In any event, it is well-established that “classifications based on disability are subject to minimal scrutiny.” *Constantine v. Rectors & Visitors of George Mason Univ.*, 411 F.3d 474, 486 (4th Cir. 2005); *see also, e.g., City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 446 (1985). Likewise, classifications based on diseases and other medical conditions are subject only to rational basis review. *See, e.g., Wilson v. Lynch*, 835 F.3d 1083, 1098 (9th Cir. 2016). Finally, courts are “reluctant to establish new suspect classes” and this concern “has even more force when the intense judicial scrutiny would be applied to the ‘specialized society’ of the military.” *Thomasson*, 80 F.3d at 928.

VII. Plaintiff Wilkins Is Ineligible To Attend the U.S. Military Academy

In their proposed order, Plaintiffs request that the government be required to consider allowing Mr. Wilkins to matriculate at the U.S. Military Academy “without regard to Plaintiff Wilkins’ age.” ECF No. 57-1, at 1. The Court should reject that request. Plaintiffs’ brief contains no argument concerning Mr. Wilkins’ eligibility for the U.S. Military Academy. Mr. Wilkins was 23 years old at the time of the complaint, *see Compl.*, ¶ 36, and is statutorily ineligible to attend. *See* 10 U.S.C. § 7446(a) (“To be eligible for admission to the Academy a candidate . . . must not have passed his twenty-third birthday[.]”). That statute has nothing to do with HIV and is not at issue here. If the HIV accession policy is amended or enjoined, Mr. Wilkins may be able to commission as an officer through other routes besides the U.S. Military Academy.

CONCLUSION

For the foregoing reasons, the Court should grant judgment in favor of Defendants.

DATE: July 5, 2023

Respectfully submitted,

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