

Before the
NEW YORK STATE DEPARTMENT OF HEALTH
and the Public Health and Health Planning Council

In the Matter of the Petition of
NEW YORKERS FOR A MODERN HEALTH CODE
for the review and repeal of Section 24-2.2 of the
New York State Sanitary Code, 10 NYCRR § 24-2.2

PETITION FOR RULEMAKING

Submitted pursuant to N.Y. Const. art. I, § 9 and
N.Y. Public Health Law § 225(4)

PETITIONER

New Yorkers for a Modern Health Code
Joe Hickerson, Board President & Executive Director

DATED

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SUBMITTED TO

Bureau of Program Counsel, Regulatory Affairs Unit
New York State Department of Health · Empire State Plaza, Corning Tower, Room 2438 · Albany, NY 12237

Executive Secretary, Public Health & Health Planning Council
New York State Department of Health · Empire State Plaza, Corning Tower, Room 1805 · Albany, NY 12237

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CASES

Boreali v. Axelrod, 71 N.Y.2d 1, 523 N.Y.S.2d 464, 517 N.E.2d 1350 (1987)

City of New York v. New St. Mark's Baths, 130 Misc. 2d 911, 497 N.Y.S.2d 979 (Sup. Ct. N.Y. Cnty. 1986), *aff'd*, 168 A.D.2d 311, 562 N.Y.S.2d 642 (1st Dep't 1990)

Matter of N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene, 23 N.Y.3d 681, 16 N.E.3d 538 (2014)

N.Y. State Health Facilities Ass'n v. Axelrod, 77 N.Y.2d 340, 568 N.Y.S.2d 1, 569 N.E.2d 860 (1991)

CONSTITUTIONAL PROVISIONS

N.Y. Const. art. I, § 9

U.S. Const. amend. I

STATUTES

N.Y. Pub. Health Law § 201

N.Y. Pub. Health Law § 206

N.Y. Pub. Health Law § 225(4), (5)(a)

N.Y. A.P.A. §§ 201-a, 202, 202-a, 202-b, 202-bb, 202-f, 203, 207

5 U.S.C. § 553(e)

REGULATIONS

10 NYCRR pt. 24 (Acquired Immune Deficiency Syndrome (AIDS))

10 NYCRR subpt. 24-2 (Prohibited Facilities), §§ 24-2.1, 24-2.2, 24-2.3 (eff. July 6, 1994)

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LEGISLATIVE MATERIALS

S. 10673, 2025–2026 Leg., Reg. Sess. (N.Y. 2026) (Public Health Modernization Act)

GOVERNMENT AND PUBLIC HEALTH AUTHORITIES

Ctrs. for Disease Control & Prevention, *HIV Risk and Prevention Estimates* (last reviewed Nov. 5, 2024)

Ctrs. for Disease Control & Prevention, *Treating HIV* (last reviewed Apr. 12, 2024)

L.A. Cnty. Dep't of Health Servs., *Report to the Board of Supervisors: Regulation of Commercial Sex Venues* (June 21, 2004)

L.A. Cnty. Dep’t of Pub. Health, *Commercial Sex Venue Enforcement*

N.Y. State Dep’t of Health, *Ending the AIDS Epidemic in New York State*

N.Y. State Dep’t of Health AIDS Inst., *U=U Policy Statement* (Nov. 1, 2018)

N.Y. State Dep’t of Health AIDS Inst. Clinical Guidelines Program, *U=U Guidance for Implementation in Clinical Settings* (updated Apr. 5, 2023)

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Mary R. Tanner et al., *Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV*, 74 MMWR Recomm. Rep. 1 (2025)

World Health Organization, *Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring: Recommendations for a Public Health Approach* (2021)

SCIENTIFIC LITERATURE

Benjamin R. Bavinton et al., *Viral Suppression and HIV Transmission in Serodiscordant Male Couples*, 5 Lancet HIV e438 (2018)

Diane Binson et al., *Differential HIV Risk in Bathhouses and Public Cruising Areas*, 91 Am. J. Pub. Health 1482 (2001)

Myron S. Cohen et al., *Antiretroviral Therapy for the Prevention of HIV-1 Transmission*, 375 New Eng. J. Med. 830 (2016)

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Étienne Meunier et al., *Attitudes Toward Peer-Delivered Sexual-Health Services Among New York City Sexual and Gender Minority Individuals Who Have Sex with Men and Attend Collective Sex Venues*, 32 Qualitative Health Rsch. 1167 (2022)

Alison J. Rodger et al., *Sexual Activity Without Condoms and Risk of HIV Transmission in Serodifferent Couples*, 316 JAMA 171 (2016)

Alison J. Rodger et al., *Risk of HIV Transmission Through Condomless Sex in Serodifferent Gay Couples (PARTNER)*, 393 Lancet 2428 (2019)

Preliminary Statement

This Petition respectfully requests that the New York State Department of Health initiate rulemaking to repeal 10 NYCRR § 24-2.2 of the New York State Sanitary Code, which prohibits any establishment from making facilities available for specified sexual activities and declares such facilities a threat to public health.¹

The regulation was adopted at the beginning of the HIV/AIDS epidemic. It was imposed by emergency resolution in October 1985 and made permanent that December,² at a time when no effective treatment existed, no biomedical means of prevention had been developed, and the mechanisms of transmission were still undetermined. Petitioner concedes the Department acted on the best information reasonably available.

Four decades later, however, the facts have changed substantively and substantially. Pre-exposure prophylaxis can reduce the risk of sexually acquired HIV by approximately 99%³; post-exposure prophylaxis interrupts infection after exposure⁴; and patients who maintain viral suppression do not transmit HIV sexually⁵, a conclusion the Department itself has formally acknowledged.⁶

These developments do not merely supplement the assumptions underlying Subpart 24-2—they supplant them. Yet § 24-2.2 remains in force unaltered since 1994, and the Department has never publicly reexamined or justified its continued existence. This Petition advances five reasons why it should do so now.

First, the Department has the authority to reconsider the regulation. The Public Health and Health Planning Council is expressly empowered to amend and repeal the Sanitary Code,⁷ and the delegation in Public Health Law § 225 is a delegation of health expertise to be exercised on an evidentiary record — a record that must remain current if the regulation is to remain defensible.⁸

1 N.Y. Comp. Codes R. & Regs. tit. 10, § 24-2.2 (2026) (“No establishment shall make facilities available for the purpose of sexual activities where anal intercourse, vaginal intercourse or fellatio take place. Such facilities shall constitute a threat to the public health.”). Subpart 24-2 is titled “Prohibited Facilities” and appears within Part 24, “Acquired Immune Deficiency Syndrome (AIDS).” Its stated statutory authority is N.Y. Pub. Health Law § 225(4), (5)(a).

2 The State Public Health Council adopted the measure by emergency resolution on October 25, 1985, and made it permanent on December 20, 1985, effective December 23, 1985. See *City of New York v. New St. Mark’s Baths*, 130 Misc.2d 911, 497 N.Y.S.2d 979 (Sup. Ct. N.Y. Cnty. 1986), *aff’d*, 168 A.D.2d 311, 562 N.Y.S.2d 642 (1st Dep’t 1990).

3 Ctrs. for Disease Control & Prevention, *HIV Risk and Prevention Estimates* (last reviewed Nov. 5, 2024) (“When taking PrEP daily or consistently . . . the risk of acquiring HIV is reduced by about 99% among MSM.”).

4 Mary R. Tanner et al., *Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV — CDC Recommendations, United States, 2025*, 74 MMWR Recomm. Rep. 1 (2025) (recommending initiation as soon as possible and no later than 72 hours after exposure, continued for 28 days).

5 Ctrs. for Disease Control & Prevention, *Treating HIV* (last reviewed Apr. 12, 2024) (“If you have an undetectable viral load, you will not transmit HIV through sex.”).

6 N.Y. State Dep’t of Health AIDS Inst., *U=U Policy Statement* (Nov. 1, 2018) (stating that “people living with HIV (PLWH) who have achieved and continue to maintain an undetectable viral load do not sexually transmit HIV”); see also N.Y. State Dep’t of Health AIDS Inst. Clinical Guidelines Program, *U=U Guidance for Implementation in Clinical Settings* (updated Apr. 5, 2023) (“People who achieve and maintain an undetectable HIV viral load do not sexually transmit HIV.”).

7 N.Y. Pub. Health Law § 225(4) (authorizing the public health and health planning council “to establish, and from time to time, amend and repeal sanitary regulations, to be known as the sanitary code of the state of New York, subject to approval by the commissioner”).

8 *Boreali v. Axelrod*, 71 N.Y.2d 1, 523 N.Y.S.2d 464, 517 N.E.2d 1350 (1987) (invalidating Public Health Council smoking regulations where the Council “wrote on a clean slate, creating its own comprehensive set of rules without benefit of legislative

Second, the scientific premises on which § 24-2.2 rests have not survived. The regulation implies a categorical judgment that certain venues propagate HIV. That judgment was formed before antiretroviral therapy, PrEP, PEP, routine testing, and the evidence establishing that viral suppression prevents transmission. Whether it remains supportable on today's record is a question only the Department can answer, but to date it has not.

Third, the regulation has escaped the standard periodic review New York law now requires. N.Y. A.P.A. § 207 obliges agencies to revisit their rules at fixed intervals, assess their continuing necessity, and justify continuation to the public.⁹ That obligation applies only to regulations adopted on or after January 1, 1997.¹⁰ Subpart 24-2 predates that threshold by roughly two and one-half years, so it has never been subjected to the review that an identical rule adopted in 1997 would have undergone five times.

Fourth, prohibition forecloses the use of regulatory tools employed effectively by other public-health authorities. Los Angeles County permits and inspects these venues,¹¹ San Francisco rescinded its restrictions in 2020,¹² and Minneapolis repealed its 1988 prohibition in 2026 in favor of licensing.¹³ Prohibition also raises the question of whether the conduct at issue has simply moved to settings where inspection, education, and testing are more difficult.¹⁴

Fifth, formal rulemaking is the mechanism New York law supplies for answering these questions. It compels notice, public comment, expert participation, deliberation by the Council, and the impact analyses that accompany any substantive rule.¹⁵ No other process can develop the contemporary record this regulation currently lacks.

guidance" and where "[n]o special expertise or technical competence in the field of health was involved"); accord *Matter of N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene*, 23 N.Y.3d 681, 16 N.E.3d 538 (2014). The delegation in § 225 is a delegation of health expertise applied to evidence. Exercising it as such — by testing an existing rule against the current scientific record — is the core of the authority, not a departure from it.

⁹N.Y. A.P.A. § 207 (requiring that rules adopted on or after the section's effective date be reviewed no later than the fifth calendar year after adoption and re-reviewed at five-year intervals, with the reviewing agency to publish notice in the regulatory agenda, "invite public comment on the continuation or modification of the rule," and provide not less than forty-five days for comment). Because § 24-2.2 predates § 207, it has never been subject to that mandatory cycle — a gap this Petition asks the Department to close voluntarily.

¹⁰N.Y. A.P.A. § 207(1) (mandatory review applies to rules "adopted on or after the effective date of this section"); accord N.Y. State Dep't of Tax'n & Fin., *Five-Year Rule Reviews* (explaining that the agency "must review all regulations adopted on or after January 1, 1997, after five years, and, thereafter, at five year intervals" under § 207).

¹¹L.A. Cnty., Cal., Code tit. 11, div. 1, ch. 11.04, pt. 3 ("Bathhouses and Similar Commercial Establishments") (eff. Nov. 10, 2005). Los Angeles County issues a public health permit to a compliant operator rather than prohibiting the category, and the Health Officer may "enter and inspect any permitted CSV, or any location reasonably suspected of operating as a CSV, for the purpose of enforcing the regulations." L.A. Cnty. Dep't of Pub. Health, *Commercial Sex Venue Enforcement*.

¹²The San Francisco Board of Supervisors and Mayor rescinded the health-code restrictions that had effectively precluded such establishments — including the prohibition on private rooms with doors and the patron-monitoring requirement — in 2020, with the Department of Public Health making the change official in January 2021. Related provisions of the San Francisco Police Code adopted in 1973 were the subject of a further repeal ordinance considered in 2024.

¹³On June 25, 2026, the Minneapolis City Council voted 9–2 (one abstention) to repeal that city's 1988 prohibition and to direct the creation of a licensing and zoning framework for establishments in which consenting adults may engage in sexual activity.

¹⁴L.A. Cnty. Dep't of Health Servs., *Report to the Board of Supervisors: Regulation of Commercial Sex Venues* (June 21, 2004). The Department recommended a permit conditioned on compliance with Health Officer guidelines requiring condom availability, on-site HIV and STD screening, staff training, and patron education, and it observed that the mid-1980s bathhouse closures in San Francisco "resulted in the development of sex clubs" — a documented governmental finding of displacement rather than elimination.

¹⁵N.Y. A.P.A. § 202 (rule making procedure, including notice of proposed rule making, public comment, and notice of adoption); *id.* § 202-a (regulatory impact statement); *id.* § 202-f (public hearings); *id.* § 203 (filing and effective date).

Petitioner does not ask the Department to repudiate its earlier judgment, abandon the public-health objectives that motivated Subpart 24-2, or predetermine the outcome of any rulemaking. Petitioner does ask the Department to determine, on a current evidentiary record, whether a categorical prohibition adopted under the extraordinary conditions of the mid-1980s remains necessary or appropriate today — and if it does not, then repeal § 24-2.2 and replace it with modern standards grounded in contemporary science.

Authority for Petition

This Petition is submitted in the exercise of the right to petition government for the redress of grievances, guaranteed by Article I, § 9 of the New York State Constitution and the First Amendment to the United States Constitution.¹⁶

The New York State Department of Health administers the State Sanitary Code under authority granted by the Public Health Law. The Public Health and Health Planning Council is expressly empowered “to establish, and from time to time, amend and repeal” the Sanitary Code, subject to the approval of the Commissioner.¹⁷ The Code may address “any matters affecting the security of life or health or the preservation and improvement of public health in the state of New York.”¹⁸

Should the Department elect to proceed, amendments to the State Sanitary Code are adopted through the rulemaking procedures prescribed by the State Administrative Procedure Act, following consideration by the Council and approval by the Commissioner.¹⁹

Accordingly, the Department possesses the authority to initiate the rulemaking requested herein.

Relief Requested

The Petitioner respectfully requests that the Department:

1. Initiate rulemaking to repeal 10 NYCRR § 24-2.2;
2. Publish a Notice of Proposed Rule Making in the New York State Register;
3. Conduct public hearings and receive comments from interested parties, including experts in infectious disease, epidemiology, constitutional law, public health, and affected stakeholders; and
4. Following review of the evidence developed during the rulemaking process, repeal § 24-2.2 as no longer necessary to accomplish the objectives for which it was originally adopted.

¹⁶The New York State Administrative Procedure Act contains no provision expressly governing petitions by members of the public for the adoption, amendment, or repeal of a rule. Cf. 5 U.S.C. § 553(e) (federal analogue). The right to submit this Petition therefore rests on N.Y. Const. art. I, § 9 and U.S. Const. amend. I, and the Department’s authority to act upon it rests on N.Y. Pub. Health Law § 225(4). Petitioner notes that *N.Y. A.P.A. § 202-b* governs regulatory flexibility analysis for small businesses and local governments and is not a petition provision; it is cited here only for the analysis the Department must prepare should it proceed to rulemaking. *See infra* Point III.

¹⁷N.Y. Pub. Health Law § 225(4), *supra* note 7.

¹⁸N.Y. Pub. Health Law § 225(5)(a) (sanitary code may address “any matters affecting the security of life or health or the preservation and improvement of public health in the state of New York”).

¹⁹N.Y. A.P.A. § 202, *supra* note 15.

Questions Presented

1. Whether the factual assumptions underlying 10 NYCRR § 24-2.2 continue to reflect current scientific knowledge concerning HIV prevention and transmission.
2. Whether advances in biomedical prevention, treatment, and public health practice warrant reconsideration of a categorical prohibition adopted during the earliest years of the HIV/AIDS epidemic.
3. Whether a regulation that predates the State’s periodic review requirement and has therefore never undergone the review now required of comparable rules, should be reviewed now.
4. Whether less restrictive regulatory approaches, if any regulation remains warranted, would adequately protect public health while avoiding unnecessary burdens upon lawful commercial activity.
5. Whether maintaining § 24-2.2 advances the Department’s commitment to evidence-based public health regulation.

Statement of Facts and Regulatory History

I. The HIV/AIDS Epidemic and the Adoption of Part 24

Part 24 of the New York State Sanitary Code — titled “Acquired Immune Deficiency Syndrome (AIDS)” — was adopted during an unprecedented public health emergency. In the early years of the epidemic, medical science had not yet identified mechanisms by which HIV could be effectively prevented or treated, and public health officials confronted a rapidly spreading communicable disease with an extraordinarily high mortality rate.

At the time of adoption, no effective antiviral therapy existed. Biomedical prevention strategies such as PrEP and PEP had not been developed. The principle now known as Undetectable=Untransmittable (U=U) had not been established through clinical research. Routine testing was far less available than today, and HIV infection was widely regarded as progressive and usually fatal. Public health authorities therefore relied principally upon behavioral interventions intended to reduce opportunities for transmission.

Within this context, the Department adopted Part 24 as a series of emergency public health measures. Subpart 24-2 prohibited establishments from making facilities available for specified sexual activities, declared such facilities to constitute a threat to the public health, and authorized State and local health officials to close them as public nuisances.²⁰ The Council’s

²⁰Subpart 24-2 comprises three sections: § 24-2.1 (Definition), which provides that “[e]stablishment shall mean any place in which entry, membership, goods or services are purchased”; § 24-2.2 (Prohibited facilities); and § 24-2.3 (Closure), which authorizes the State Health Commissioner, local health officers, and local boards of health to “close any such facilities or establishments as constituting a public nuisance.”

contemporaneous findings recorded its judgment that such establishments “contribute to the propagation and spread” of the virus.²¹

That judgment was a reasonable exercise of emergency public-health authority on the record then available. Petitioner does not contend otherwise, and nothing in this Petition should be read as a criticism of the Department’s conduct in 1985.

II. Advances in HIV Prevention and Treatment

Since the adoption of Part 24, the science of HIV prevention has undergone a transformation without close parallel in modern communicable-disease control.

Modern antiretroviral therapy permits many persons living with HIV to achieve sustained viral suppression, dramatically improving health outcomes and, according to current scientific consensus, preventing sexual transmission where suppression is maintained. That conclusion rests on a series of large prospective studies: HPTN 052,²² the PARTNER study,²³ PARTNER2,²⁴ and Opposites Attract.²⁵ Across these studies, investigators observed no phylogenetically linked transmissions from a virally suppressed partner over tens of thousands of acts of condomless sex.

Alongside treatment as prevention, the contemporary toolkit includes:

- Pre-exposure prophylaxis, which reduces the risk of sexual acquisition by approximately 99% when taken as prescribed;²⁶
- Post-exposure prophylaxis, which can interrupt infection when initiated promptly after exposure;²⁷
- Routine screening, rapid diagnosis, and immediate initiation of therapy following diagnosis;
- Condom and lubricant availability, partner services, and sexually transmitted infection screening and treatment; and
- Expanded public health education, surveillance, and linkage-to-care programs.

²¹*New St. Mark’s Baths*, 130 Misc. 2d 911, 497 N.Y.S.2d 979 (quoting the Public Health Council’s finding that “[e]stablishments including certain bars, clubs and bathhouses which are used as places for engaging in high risk sexual activities contribute to the propagation and spread of such AIDS-associated retro-viruses”).

²²Myron S. Cohen et al., *Antiretroviral Therapy for the Prevention of HIV-1 Transmission*, 375 New Eng. J. Med. 830 (2016) (final results of HPTN 052, reporting a sustained reduction in genetically linked HIV-1 infections among partners of participants receiving early antiretroviral therapy); *see also* Myron S. Cohen et al., *Prevention of HIV-1 Infection with Early Antiretroviral Therapy*, 365 New Eng. J. Med. 493 (2011) (interim results reporting a 96% reduction in linked transmissions).

²³Alison J. Rodger et al., *Sexual Activity Without Condoms and Risk of HIV Transmission in Serodifferent Couples When the HIV-Positive Partner Is Using Suppressive Antiretroviral Therapy*, 316 JAMA 171 (2016) (888 couples; 1,238 couple-years of follow-up; approximately 58,000 condomless sex acts; zero phylogenetically linked transmissions).

²⁴Alison J. Rodger et al., *Risk of HIV Transmission Through Condomless Sex in Serodifferent Gay Couples with the HIV-Positive Partner Taking Suppressive Antiretroviral Therapy (PARTNER): Final Results of a Multicentre, Prospective, Observational Study*, 393 Lancet 2428 (2019) (783 gay male couples; 1,596 eligible couple-years of follow-up; approximately 76,991 condomless sex acts; zero phylogenetically linked within-couple transmissions).

²⁵Benjamin R. Bavinton et al., *Viral Suppression and HIV Transmission in Serodiscordant Male Couples: An International, Prospective, Observational, Cohort Study*, 5 Lancet HIV e438 (2018) (343 serodiscordant male couples; 232.2 couple-years and 12,447 acts of condomless anal intercourse during periods of viral suppression; zero linked transmissions).

²⁶CDC, HIV Risk and Prevention Estimates, *supra* note 3.

²⁷Tanner et al., *supra* note 4.

These developments are reflected in the guidance of the Centers for Disease Control and Prevention, the World Health Organization, and this Department.²⁸ New York has incorporated them into statewide policy through testing initiatives, expanded PrEP access, treatment recommendations, and the Ending the Epidemic initiative,²⁹ and the Department's own U=U policy statement commits it to incorporating that science into "all prevention-related program activities."³⁰

The result is that HIV prevention today operates principally through biomedical and behavioral interventions directed toward individuals, rather than through restrictions on the locations where sexual activity may occur.

III. Subpart 24-2 Since Adoption

Against that changed landscape, Subpart 24-2 has remained essentially static. The provisions now codified at §§ 24-2.1 through 24-2.3 were amended in 1994, and the Department's Title 10 database continues to identify July 6, 1994 as their effective date.³¹ Petitioner has located no subsequent amendment.

The 1994 amendments revised the wording of the prohibition — adding vaginal intercourse to the enumerated activities and removing the earlier defined phrase "high risk sexual activity" — but left its architecture intact.³² They did not replace the categorical prohibition with a framework based upon risk reduction, safer-sex practices, operating standards, inspection, or any other public-health control. The rule that governs today is, in substance, the rule adopted in response to the 1985 emergency.

The continued existence of the regulation does not itself establish that its factual premises remain valid, and the passage of time alone does not establish that it has become obsolete. The question is whether current scientific evidence still supports the categorical judgment the regulation embodies: that the establishments it prohibits constitute a continuing threat to public health.

²⁸Centers for Disease Control & Prevention, *HIV Risk and Prevention Estimates* (last reviewed Nov. 5, 2024) ("For persons who achieve and maintain viral suppression, studies have shown no risk of sexual transmission.").

²⁹N.Y. State Dep't of Health, *Ending the AIDS Epidemic in New York State*; see also Press Release, N.Y. State Dep't of Health, *HIV Surveillance Report* (Dec. 1, 2025) (reporting a 36% decrease in newly diagnosed HIV cases from 2011 to 2024 and a 26% decrease since 2014, and noting elimination of perinatal HIV transmission for ten consecutive years).

³⁰NYSDOH AIDS Inst., U=U Policy Statement, *supra* note 6.

³¹N.Y. State Dep't of Health, New York Codes, Rules and Regulations tit. 10, §§ 24-2.1, 24-2.2, 24-2.3 (regs.health.ny.gov) (each section listing an effective date of 07/06/1994; retrieved Sept. 15, 2026).

³²The current version of Subpart 24-2 carries an effective date of July 6, 1994. The 1985 measure reached "high risk sexual activity," then defined by 10 NYCRR § 24-2.1 as "anal intercourse and fellatio"; the current § 24-2.2 enumerates anal intercourse, vaginal intercourse, and fellatio, and § 24-2.1 now defines "establishment" instead. See *New St. Mark's Baths*, 130 Misc. 2d 911, 497 N.Y.S.2d 979. The categorical form of the prohibition — and the declaration that such facilities constitute a threat to the public health — is unchanged. That the Department has amended this Subpart before confirms that it may do so again.

Argument

POINT I. The Department Has the Authority to Ensure the Sanitary Code Rests on Current Science.

The authority delegated to the Department and to the Public Health and Health Planning Council is not limited to promulgating new regulations. It expressly includes the power to amend and repeal the Sanitary Code,³³ and the State Administrative Procedure Act contemplates the same, directing agencies to revisit their rules periodically.³⁴ Those grants necessarily include discretion to reconsider a regulation when changed circumstances call its continued necessity into question.

The obligation to exercise that discretion follows from the nature of the delegation. The Public Health Law entrusts the Department with protecting the health of the people of New York,³⁵ and the delegation in § 225 is a delegation of health expertise to be applied to an evidentiary record. The Court of Appeals has cautioned that the Council's authority is at its weakest where "[n]o special expertise or technical competence in the field of health" is brought to bear.³⁶ A regulation sustained by expertise must be maintained by expertise.

That principle also describes what sustains a regulation on review. Regulations of this Department have been upheld where the standard adopted rested on a rational evidentiary basis, reasonableness being the test.³⁷ Courts will not choose between competing scientific views in assessing an exercise of the police power,³⁸ which means the responsibility for keeping the underlying judgment current rests with the Department rather than with any reviewing court. A record assembled in 1985 cannot indefinitely supply that basis for conditions prevailing in 2026.

The Department has repeatedly revised guidance, recommendations, and regulatory approaches as medical knowledge has developed. Such revisions reflect neither inconsistency nor retreat; they embody the principle that public health policy should follow the best available evidence. Reconsidering § 24-2.2 on a contemporary record would not repudiate the Department's 1985 judgment. It would demonstrate that the Department continues to fulfill the purpose for which its rulemaking authority was delegated.

³³N.Y. Pub. Health Law § 225(4), *supra* note 7.

³⁴N.Y. A.P.A. § 207, *supra* note 9.

³⁵N.Y. Pub. Health Law § 201 (functions, powers and duties of the Department); *id.* § 206 (general powers and duties of the Commissioner).

³⁶Boreali, *supra* note 8.

³⁷*N.Y. State Health Facilities Ass'n v. Axelrod*, 77 N.Y.2d 340, 568 N.Y.S.2d 1, 569 N.E.2d 860 (1991) (upholding Department regulations as a valid exercise of delegated authority where the regulatory standard rested on a rational evidentiary basis; "[r]easonableness is the test").

³⁸*New St. Mark's Baths*, 130 Misc. 2d 911, 497 N.Y.S.2d 979 ("It is not for the courts to determine which scientific view is correct in ruling upon whether the police power has been properly exercised."). That standard of judicial restraint underscores, rather than diminishes, the Department's own obligation to keep the scientific premises of its regulations current: if the courts will not revisit the Council's scientific judgment, the Council must.

POINT II. The Scientific Premises on Which Section 24-2.2 Rests Have Fundamentally Changed in the Intervening Four Decades.

Section 24-2.2 is not an operating requirement. It is a categorical judgment about disease causation: that establishments making facilities available for the enumerated activities propagate HIV and therefore constitute a threat to the public health warranting prohibition rather than regulation.

That judgment was formed under the conditions described above — no effective therapy, no biomedical prophylaxis, limited testing, and an incomplete understanding of transmission. Each of those premises has since been displaced. Antiretroviral therapy has converted HIV into a manageable chronic condition and, where viral suppression is maintained, eliminates the risk of sexual transmission. PrEP and PEP supply protection that operates independently of where sexual activity occurs. Routine screening and immediate treatment have become the organizing features of prevention policy, in this State as elsewhere.

The significance of these developments is structural, not incremental. A venue-based prohibition presupposes that location is a meaningful lever on transmission risk. Contemporary prevention science locates that lever principally in the biomedical and behavioral status of individuals — whether a person is on PrEP, whether a person living with HIV is virally suppressed, whether testing and treatment are accessible. The Department has itself adopted that framework as statewide policy. Section 24-2.2 has never been evaluated against it.

Petitioner does not assert that the answer is self-evident, that all venue-associated public-health concerns have disappeared, or that advances in HIV medicine displace the State’s authority to regulate communicable disease. Venue-specific interventions may well be justified on a proper record. The submission is narrower: that a categorical prohibition should be supported by current evidence that the prohibition remains necessary, and that four decades of scientific development are more than sufficient to require the Department to ask whether such evidence exists.

The Department is uniquely qualified to make that assessment. It can weigh epidemiological evidence, peer-reviewed literature, and expert testimony, and it can do so through notice, public comment, and deliberation by the Council. If the resulting record shows that § 24-2.2 provides a substantial benefit not achievable by less restrictive means, the Department may retain or amend it. If the record shows otherwise, repeal or revision would vindicate the same obligation.

POINT III. Subpart 24-2 Has Escaped New York’s Periodic Review Requirement

The regulation has remained substantially unchanged since 1994 and appears never to have undergone the periodic, public, evidence-based review that New York subsequently made a standard feature of its administrative law.

A. New York Law Now Requires Agencies to Reconsider Whether Rules Remain Necessary.

In enacting N.Y. A.P.A. § 207, the Legislature established a mechanism designed to prevent regulations from remaining indefinitely in force without reconsideration. For rules within its scope, an agency must conduct an initial review no later than the fifth calendar year following

adoption and another review at five-year intervals thereafter;³⁹ rules accompanied by specified regulatory-impact analyses are reviewed even sooner.⁴⁰

The review is substantive and public. The agency must identify the rule in its January regulatory agenda, analyze its continuing need and legal basis, and invite public comment on whether the rule should be continued or modified, allowing not less than forty-five days.⁴¹ The agency cannot then leave the rule in place by inertia: if modification is warranted it must initiate rulemaking and justify the proposed change — expressly considering, where appropriate, whether developments in technology, economic conditions, or the regulated field require it;⁴² and if it elects to continue the rule unchanged it must publish a reasoned justification for continuation and assess the comments received.⁴³

Section 207 thus embodies a basic principle of modern New York administrative law: a regulation's original justification is not necessarily sufficient forever. Circumstances change, technology changes, and knowledge changes. Rules should be periodically tested against present conditions rather than perpetuated because they once served a legitimate purpose.

B. Subpart 24-2 Predates That System and Therefore Appears to Have Escaped It.

Section 207's mandatory review regime applies prospectively, to rules adopted on or after January 1, 1997.⁴⁴ Because the operative provisions of Subpart 24-2 were adopted in 1985 and last amended effective July 6, 1994,⁴⁵ the regulation appears to have been grandfathered outside the mandatory periodic-review process — by roughly two and one-half years.

The disparity is striking. Had a materially identical prohibition first been adopted in 1997, § 207 would ordinarily have required an initial review no later than 2002 and further reviews in 2007, 2012, 2017, and 2022.⁴⁶ At each of those reviews the Department would have been required to place the rule before the public, examine its continuing need and legal basis, receive comment on modification or continuation, and publish a reasoned justification for whichever course it chose.

Subpart 24-2 apparently received none of them — not because the subject matter became less important, and not because the Department affirmatively determined after public review that a categorical prohibition remained optimal policy, but because the rule happened to predate the statutory threshold. Thus, paradoxically, the age of Subpart 24-2 — the very circumstance that

³⁹N.Y. A.P.A. § 207(1)(a) (rules subject to the section generally must be reviewed no later than the fifth calendar year after adoption, and at five-year intervals thereafter).

⁴⁰N.Y. A.P.A. § 207(1)(b) (rules for which a regulatory flexibility analysis, rural area flexibility analysis, or job impact statement was prepared are subject to an earlier initial review).

⁴¹N.Y. A.P.A. § 207(2) (agency must identify the rule in its January regulatory agenda, provide an analysis of the continuing need for and legal basis of the rule, and invite public comment on its continuation or modification, allowing not less than forty-five days for comment).

⁴²N.Y. A.P.A. § 207(3) (if the agency determines that modification is warranted, it must initiate rulemaking and provide a reasoned justification for the proposed modification, considering, where appropriate, changes in technology, economic conditions, compliance requirements, or other developments affecting the subject of the rule).

⁴³N.Y. A.P.A. § 207(4) (if the agency elects to continue the rule unchanged, it must publish a notice providing a reasoned justification for continuation and assessing the public comments received).

⁴⁴N.Y. A.P.A. § 207(1), *supra* note 10.

⁴⁵10 NYCRR §§ 24-2.1–24-2.3 (regs.health.ny.gov), *supra* note 31.

⁴⁶N.Y. A.P.A. § 207(1)(a), *supra* note 39.

makes reconsideration most important — is also the circumstance that has prevented it. That accident of regulatory timing should not substitute for substantive evaluation.

C. No Public Record Shows the Department Has Ever Made the Determination § 207 Would Require of a Comparable Modern Rule.

Petitioner’s review of the publicly available regulatory history has located no published § 207 continuation determination, regulatory-agenda review, public-comment process, or comparable proceeding in which the Department analyzed the continuing necessity of Subpart 24-2 under contemporary conditions.

Petitioner does not contend that this constitutes a violation of § 207, because the regulation appears to fall outside the statute’s prospective effective-date provision. Nor does Petitioner represent, absent complete agency and Department of State records, that no internal or voluntary review has ever occurred. The narrower point is both supportable and consequential: no publicly documented review has been identified in which the Department subjected this prohibition to the process of evidence, public participation, and reasoned justification that New York now requires for covered regulations.

Accordingly, there appears to be no contemporary administrative record explaining why the categorical prohibition remains necessary in its present form; no published assessment comparing it with less restrictive alternatives; no public-comment proceeding asking whether it should be modified; and no reasoned continuation determination addressing the changes in HIV prevention and treatment that have occurred since 1994.

D. Grandfathering Is a Reason to Conduct Review Now, Not a Reason to Preserve Status Quo.

The Department should not treat Subpart 24-2’s technical exclusion from mandatory review as evidence that review is unnecessary. The better conclusion is the reverse. Section 207 reflects a legislative judgment that rules should not continue indefinitely merely because no one has formally initiated their reconsideration; it exists precisely because administrative inertia can otherwise preserve rules after the conditions that produced them have changed.

Subpart 24-2 is an unusually compelling case for applying that principle voluntarily. The rule:

1. Was conceived during an extraordinary public-health emergency and adopted initially through emergency procedures;
2. Was last amended in 1994 and predates the State’s modern periodic-review statute;
3. Appears never to have been required to undergo periodic § 207 review;
4. Regulates a field in which medical science, prevention technology, treatment, and public-health practice have changed dramatically; and
5. Continues to impose a categorical prohibition rather than a framework capable of incorporating new developments.

The result is a regulatory blind spot: one of the State’s oldest surviving AIDS-era restrictions has been insulated from the very mechanism New York later created to ensure that longstanding

regulations remain justified by contemporary facts. The Department has ample authority to correct that anomaly without waiting for § 207 to compel it.

POINT IV. Prohibition Forecloses the Use of Effective Regulatory Tools Employed by Other Public-Health Authorities

The fundamental purpose of the State Sanitary Code is the protection of public health, and a regulation should be judged not only by its original objectives but by its present operation and practical consequences. Section 24-2.2 operates as an absolute bar. In doing so it forecloses the possibility of an establishment operating under health and safety requirements designed for such venues — and with it, the oversight that licensure and inspection would supply.

That foreclosure has an empirical cost the Department has never measured. If conduct that would otherwise occur within regulated establishments instead occurs in informal, transient, or unlicensed settings, those settings are correspondingly less accessible to inspection, education, testing, and outreach. At least one public-health agency has made a finding to that effect: in recommending a permit regime, the Los Angeles County Department of Health Services observed that the mid-1980s closures in San Francisco “resulted in the development of sex clubs.”⁴⁷ Clinicians who have worked in such venues have likewise reported that they can serve as effective sites for outreach and prevention.⁴⁸

Petitioner does not assert as established fact that § 24-2.2 has caused such displacement in New York. The submission is that the question is reasonable, material, and appropriate for administrative investigation — and that it cannot be answered without the evidence that rulemaking would develop.

New York’s approach is also no longer the prevailing model. Los Angeles County regulates these establishments through a public health permit rather than prohibition, conditioned on compliance with Health Officer guidelines and subject to routine inspection.⁴⁹ That framework was adopted in 2005 — two decades after New York’s prohibition and well into the modern treatment era — following a departmental recommendation that regulation, condom availability, on-site screening, and staff training would better serve disease-prevention objectives than closure.⁵⁰ San Francisco rescinded the health-code restrictions that had effectively precluded such establishments in 2020,⁵¹ and in June 2026 the Minneapolis City Council voted to repeal that city’s 1988 prohibition in favor of a licensing and zoning framework.⁵²

These jurisdictions do not establish that New York’s regulation is unlawful or ineffective. They establish something more modest and more useful: that alternatives exist, that public-health

⁴⁷L.A. Cnty. DHS Report (2004), *supra* note 14.

⁴⁸Statement of Demetre Daskalakis, M.D., M.P.H., Chief Medical Officer, Callen-Lorde Community Health Center, in Press Release, N.Y. State Senate, *Senator Bottcher and Assemblymember Simone Introduce Bill to Repeal 1985 Ban on Adult Saunas* (Aug. 5, 2026) (“My own work in these venues has shown that they can also be powerful environments for health outreach and prevention.”). Petitioner offers this statement as an illustration of the empirical question presented, not as established fact.

⁴⁹L.A. Cnty. Code ch. 11.04, pt. 3, *supra* note 11.

⁵⁰L.A. Cnty. DHS Report (2004), *supra* note 14.

⁵¹San Francisco Rescission, *supra* note 12.

⁵²Minneapolis Repeal, *supra* note 13.

authorities applying contemporary science have adopted them in preference to prohibition, and that their comparative effectiveness is precisely the kind of question an administrative record can resolve.

Should the Department conclude that these venues present genuine public-health concerns, repeal need not mean regulatory abandonment. The Los Angeles County framework supplies a working model — a permit conditioned upon compliance with Health Officer guidelines requiring condom availability, on-site HIV and STD screening, staff training, and patron education, enforced through inspection authority and graduated sanctions rather than a binary choice between closure and operation. Measures available for consideration include:

- Licensing, sanitation standards, occupancy limits, and regular health inspections;
- Cleaning and disinfection protocols and, where supported by evidence, ventilation requirements;
- Ready availability of condoms and lubricants, and educational materials concerning HIV and other sexually transmitted infections;
- Employee training, record-keeping sufficient to demonstrate compliance, and administrative penalties for violations; and
- Cooperation with approved public-health outreach, including on-site testing, PrEP and PEP promotion, and referrals to treatment.

Regulated establishments could thus become sites of public-health intervention rather than places beyond its reach. Many industries presenting public-health considerations operate under detailed standards rather than blanket bans, and Petitioner does not contend that every establishment would satisfy appropriate standards or that repeal should eliminate all regulation. The point is that prohibition should not be presumed the only available approach without evaluating whether contemporary alternatives can provide equal or greater protection.

POINT V. Formal Rulemaking Is the Appropriate Mechanism for Developing the Record These Questions Require.

The relief requested is intentionally measured. Petitioner does not ask the Department to repeal § 24-2.2 immediately, without deliberation, or on a predetermined view of the outcome. Petitioner asks the Department to employ the process New York law supplies for reconsidering existing regulations.

Formal rulemaking provides protections unavailable through informal policy development. Publication in the New York State Register ensures public notice. Public comment permits participation by scientists, physicians, epidemiologists, local governments, affected businesses, advocacy organizations, and members of the public. Consideration by the Public Health and Health Planning Council brings scientific and professional expertise to bear.⁵³ The process would also require the Department to prepare the analyses that accompany any substantive rule — a regulatory impact statement, a regulatory flexibility analysis for small businesses and local

⁵³N.Y. A.P.A. § 202, *supra* note 15.

governments, a rural area flexibility analysis, and a job impact statement — each of which would independently document the practical consequences of retaining or repealing the regulation.⁵⁴

The present record supporting § 24-2.2 necessarily reflects the understanding available at adoption. A rulemaking would allow the Department to supplement it, addressing at a minimum:

- The original findings and scientific rationale supporting adoption, and whether they remain supported by current evidence;
- Changes since 1994 in HIV prevention, treatment, testing, and transmission, and in the prevention and treatment of other sexually transmitted infections;
- The Department’s enforcement history under §§ 24-2.2 and 24-2.3, and whether enforcement has measurably advanced the regulation’s intended objectives;
- Whether comparable activity now occurs outside regulated settings, and with what public-health consequences;
- The experience of jurisdictions employing regulatory approaches different from New York’s, and the epidemiological evidence concerning them;
- Whether inspection, sanitation, licensing, prevention, testing, education, and operational requirements would serve the Department’s objectives as well as or better than prohibition; and
- Public and expert comment concerning continuation, modification, or repeal.

Each of these questions is empirical rather than ideological, falls within the Department’s institutional competence, and is appropriately addressed through rulemaking rather than assumed in either direction.

Petitioner further notes that legislation now pending before the New York State Senate and Assembly would repeal Subpart 24-2 and direct the Department to establish modern licensing standards in its place.⁵⁵ The Department’s authority to develop a contemporary record does not depend upon that legislation. Should the Legislature act, however, a record developed now would place the Department in a substantially better position to implement any resulting mandate.

A regulation addressing infectious-disease prevention should reflect changes in infectious-disease science, and a regulation addressing public health should reflect changes in public-health practice. Section 24-2.2 does neither. It has remained substantially unchanged since 1994, resting on a scientific record assembled in 1985, insulated by an accident of timing from the review New York requires of comparable rules — and it forecloses, categorically, the use of regulatory tools other public-health authorities have since adopted. Those are reasons to ask the question, not ignore it.

⁵⁴N.Y. A.P.A. § 202-a (regulatory impact statement); *id.* § 202-b (regulatory flexibility analysis for small businesses and local governments); *id.* § 202-bb (rural area flexibility analysis); *id.* § 201-a (job impact statement).

⁵⁵S. 10673, 2025–2026 Leg., Reg. Sess. (N.Y. 2026) (the “Public Health Modernization Act,” introduced Aug. 3, 2026 by Senator Erik Bottcher, with an Assembly companion introduced by Assemblymember Tony Simone), which would repeal 10 NYCRR Subpart 24-2 in its entirety and direct the Department to promulgate “minimum standards to promote the health and safety of patrons and employees, consistent with modern public health strategies.” Petitioner notes the bill because it reflects legislative attention to the same question; the Department’s authority to act under N.Y. Pub. Health Law § 225(4) is independent of the bill’s passage, and nothing in this Petition depends upon it.

Conclusion

Given that public health is best served when regulations are periodically evaluated to ensure they remain necessary, effective, and supported by contemporary evidence, the Petitioner respectfully requests that the New York State Department of Health:

1. Accept and docket this Petition;
2. Determine that the issues presented warrant formal consideration through administrative rulemaking;
3. Initiate proceedings to repeal or amend 10 NYCRR § 24-2.2;
4. Refer the proposed rulemaking to the Public Health and Health Planning Council for consideration;
5. Publish a Notice of Proposed Rule Making in the New York State Register;
6. Solicit public comment from interested persons, including physicians, epidemiologists, public-health experts, HIV researchers, affected communities, business owners, and the public;
7. Conduct such hearings or informational proceedings as the Department deems appropriate;
8. Develop a contemporary administrative record concerning advances in HIV prevention and treatment, the effectiveness and enforcement history of § 24-2.2, available regulatory alternatives, and the public-health consequences of repeal, retention, or amendment; and
9. Following review of that record, repeal § 24-2.2 or replace it with regulations more appropriately tailored to contemporary scientific knowledge and public-health practice.

Granting this Petition would not predetermine the outcome of rulemaking. It would permit the Department to fulfill its continuing responsibility to ensure that the State Sanitary Code remains grounded in current scientific evidence and advances the health of the people of New York.

Proposed Regulatory Text

Primary Proposal

The Petitioner respectfully proposes that 10 NYCRR § 24-2.2 be repealed in its entirety.

Current text:

No establishment shall make facilities available for the purpose of sexual activities where anal intercourse, vaginal intercourse or fellatio take place. Such facilities shall constitute a threat to the public health.

Proposed amendment:

Section 24-2.2 is REPEALED.

Because § 24-2.3 authorizes closure of “such facilities or establishments” as defined by reference to § 24-2.2, the Department should determine whether §§ 24-2.1 and 24-2.3 retain independent operative effect following repeal, or whether Subpart 24-2 should be repealed in its entirety.⁵⁶

Alternative Proposal

Should the Department determine that continued regulation is appropriate, the Petitioner requests that it consider replacing the existing prohibition with a framework emphasizing health and safety standards rather than categorical prohibition.

Illustrative topics include licensing, sanitation, inspection authority, occupancy, evidence-based cleaning and maintenance, employee training, public-health educational materials, condom availability, cooperation with outreach programs, and administrative enforcement. The Los Angeles County permit framework offers one tested model.⁵⁷

The Petitioner does not propose replacement language at this time but will do so under separate cover if the Department initiates formal rulemaking, including a full review of regulations employed by other jurisdictions and testimony from experts.

⁵⁶10 NYCRR subpt. 24-2, supra note 20.

⁵⁷L.A. Cnty. Code ch. 11.04, pt. 3, supra note 11.

Appendices

This Petition is supported by the appendices below.

Appendix A — Official Text of 10 NYCRR §§ 24-2.1–24-2.3

The following is the official text of Subpart 24-2 of the New York State Sanitary Code.⁵⁸

§ 24-2.1. Definition.

Establishment shall mean any place in which entry, membership, goods or services are purchased.

§ 24-2.2. Prohibited facilities.

No establishment shall make facilities available for the purpose of sexual activities where anal intercourse, vaginal intercourse or fellatio take place. Such facilities shall constitute a threat to the public health.

§ 24-2.3. Closure.

In addition to any other power they may have under any applicable law, ordinance or regulations, the State Health Commissioner, local health officers and local boards of health may close any such facilities or establishments as constituting a public nuisance.

Subpart 24-2 is codified within Part 24 ("Acquired Immune Deficiency Syndrome (AIDS)") of the State Sanitary Code and carries a current effective date of July 6, 1994.⁵⁹

Appendix B — Regulatory History

The following chronology reflects the regulatory history of Subpart 24-2 as established by the reported case law and the current codification:

- **October 25, 1985** — The State Public Health Council adopts an emergency resolution restricting high-risk sexual activity in certain establishments that became Subpart 24-2.⁶⁰
- **December 20, 1985** — The Council adopts the measure on a permanent basis, effective December 23, 1985.
- **1986** — The City of New York invokes the regulation to close the St. Mark's Baths; the closure is upheld in *City of New York v. New St. Mark's Baths*.⁶¹
- **July 6, 1994** — The current codification of Subpart 24-2 (Appendix A) takes effect.⁶²

The Department's complete rulemaking file for Part 24, including the original Notice of Proposed Rule Making, Public Health Council meeting materials, Commissioner's approval, and Regulatory Impact Statement, is a matter of public record maintained by the Department.

⁵⁸N.Y. Comp. Codes R. & Regs. tit. 10, §§ 24-2.1–24-2.3, as posted by the New York State Department of Health and the Cornell Legal Information Institute (retrieved Sept. 4, 2026). Petitioner will supply a certified copy upon request.

⁵⁹10 NYCRR §§ 24-2.1–24-2.3 (regs.health.ny.gov), supra note 31.

⁶⁰New St. Mark's Baths, 130 Misc. 2d 911, supra note 2.

⁶¹New St. Mark's Baths, 130 Misc. 2d 911, supra note 2.

⁶²Current Codification of Subpart 24-2, supra note 32.

Appendix C — Scientific Authorities

- Cohen et al., *Prevention of HIV-1 Infection with Early Antiretroviral Therapy*, 365 New Eng. J. Med. 493 (2011) (HPTN 052, interim).
- Cohen et al., *Antiretroviral Therapy for the Prevention of HIV-1 Transmission*, 375 New Eng. J. Med. 830 (2016) (HPTN 052, final).
- Rodger et al., *Sexual Activity Without Condoms and Risk of HIV Transmission in Serodifferent Couples*, 316 JAMA 171 (2016) (PARTNER).
- Rodger et al., *Risk of HIV Transmission Through Condomless Sex in Serodifferent Gay Couples (PARTNER)*, 393 Lancet 2428 (2019) (PARTNER2).
- Bavinton et al., *Viral Suppression and HIV Transmission in Serodiscordant Male Couples*, 5 Lancet HIV e438 (2018) (Opposites Attract).
- Tanner et al., *Antiretroviral Postexposure Prophylaxis After Nonoccupational Exposure to HIV*, 74 MMWR Recomm. Rep. 1 (2025).
- CDC, *HIV Risk and Prevention Estimates* (last reviewed Nov. 5, 2024); CDC, *Treating HIV* (last reviewed Apr. 12, 2024).
- NYSDOH AIDS Institute, *U=U Policy Statement* (Nov. 1, 2018); Clinical Guidelines Program, *U=U Guidance for Implementation in Clinical Settings* (updated Apr. 5, 2023).
- World Health Organization, *Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring: Recommendations for a Public Health Approach* (2021).
- Étienne Meunier et al., *Attitudes Toward Peer-Delivered Sexual-Health Services Among New York City Sexual and Gender Minority Individuals Who Have Sex with Men and Attend Collective Sex Venues*, 32 Qualitative Health Rsch. 1167 (2022).
- Diane Binson et al., *Differential HIV Risk in Bathhouses and Public Cruising Areas*, 91 Am. J. Pub. Health 1482 (2001).

Appendix D — Comparative Regulatory Survey

- Los Angeles County: Code tit. 11, div. 1, ch. 11.04, pt. 3 (eff. Nov. 10, 2005); Dep’t of Health Servs., *Report to the Board of Supervisors: Regulation of Commercial Sex Venues* (June 21, 2004); Dep’t of Pub. Health, *Commercial Sex Venue Enforcement*.
- San Francisco: rescission of health-code restrictions (2020, effective January 2021) and related Police Code repeal measures (2024).
- Minneapolis: City Council repeal of the 1988 prohibition and adoption of a licensing framework (June 25, 2026).
- For every additional jurisdiction examined during rulemaking: statutory authority; state and local regulatory approach; licensing; inspection; sanitation; zoning; enforcement; preemption; and relevant epidemiological information.