

State Adolescent Consent Laws and Implications for HIV Pre-Exposure Prophylaxis

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Abstract

Background: Recent large clinical trials have found pre-exposure prophylaxis (PrEP) reduced HIV infection among men who have sex with men (MSM), but efforts to provide clinical care to minors, including young MSM, may be complicated by a lack of clarity regarding parental consent requirements with respect to medical services.

Purpose: The goal of this paper was to analyze law related to a minor's ability to consent to medical care, including HIV diagnostic testing and treatment, and its implications for PrEP.

Methods: Analysis was performed in 2012 on laws current as of December 31, 2011. Public Health Law Program staff collected all statutes and regulations pertaining to an adolescent's ability to consent to HIV diagnostic testing and treatment and sexually transmitted infection (STI) diagnostic testing, treatment, and prevention.

Results: No state expressly prohibits minors' access to PrEP or other HIV prevention methods. All jurisdictions expressly allow some minors to consent to medical care for the diagnosis or treatment of STIs, but only eight jurisdictions allow consent to preventive or prophylactic services. Thirty-four states either expressly allow minors to consent to HIV services or allow consent to STI or communicable disease services and classify HIV as an STI or communicable disease. Seventeen jurisdictions allow minors to consent to STI testing and treatment, but they do not have an express HIV provision nor classify HIV as an STI or communicable disease.

Conclusions: Minors' access to PrEP without parental consent is unclear, and further analysis is needed to evaluate how state law may relate to the provision of clinical interventions for the prevention of HIV infection.

Background

Pre-exposure prophylaxis (PrEP) is an HIV prevention approach in which people who are at high risk for acquiring HIV take daily oral doses of antiretroviral medication in an effort to lower their risk of becoming infected with HIV. The antiretroviral medication used for PrEP is a fixed-dose combination of tenofovir disoproxil fumarate and emtricitabine (Truvada[®]). It currently has an U.S. Food and Drug Administration (FDA) labeling indication for the treatment of HIV infection, and a decision about a labeling indication for prevention of sexual acquisition of HIV infection is pending. Recent large clinical trials have found PrEP reduced HIV infection among men who have sex with men (MSM)¹ as well as heterosexual men and women.²

Although the annual number of new HIV infections in the U.S. was stable overall from 2006 through 2009, there was an estimated 21% increase in HIV incidence in people aged 13–29 years. This increase in HIV incidence was driven by a 34% increase in HIV incidence in young MSM (the only group to experience a significant increase in incidence in this age range).³ The increasing number of new HIV infections among young gay and bisexual men underscores the importance of reaching young MSM with effective HIV prevention programs.

However, efforts to provide clinical care to minors, including young MSM, may be complicated by a lack of clarity regarding parental consent requirements with respect to medical services.

¹ Grant RM, Lama JR, Anderson PL, et al. Preexposure chemoprophylaxis for HIV prevention in men who have sex with men. *N Engl J Med*. 2010;363(27):2587-2599.

² Baeten J, Donnell D, Ndase P, et al. ARV PrEP for HIV-1 Prevention among Heterosexual Men and Women. Conference on Retroviruses and Opportunistic Infections 2012. www.retroconference.org/2012b/Abstracts/43082.htm.

³ Prejean J, Song R, Hernandez A, et al. Estimated HIV Incidence in the U.S., 2006–2009. *PLoS ONE*. 2011;6(8):e17502.

Young MSM may be reluctant or unwilling to disclose their sexual orientation or sexual activities to their parents and may be deterred from seeking medical services, such as PrEP, if parental consent is required. Minor consent for medical care raises complicated issues with several competing interests, including parental rights to make medical decisions for minor children, confidentiality between physician and patient, and privacy rights of minors with respect to certain types of health care, particularly sexual and reproductive health care.

Although the U.S. Supreme Court has affirmed the right of parents to make decisions regarding the care of their children,⁴ the rights of parenthood are not without limitation.⁵ In the past few decades, the Supreme Court has recognized that minors themselves have constitutional rights. In particular, the court has established that minors have a constitutionally protected right to privacy,⁶ including decisions regarding procreation. The Supreme Court rejected a district court's suggestion that parental consent requirements were necessary to safeguard the family unit and parental authority, holding that allowing a parent to overrule a reproductive healthcare decision made by a minor child and her physician was unlikely to either strengthen the family unit or enhance parental control.⁷

Further, although parents in most instances must consent for medical services provided to their minor children, case law and legislation have evolved in recent decades to allow minors to

⁴ Pierce v. Soc'y of the Sisters of the Holy Names of Jesus & Mary, 268 U.S. 510, 535 (1925). "It is cardinal with us that the custody, care, and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder." Prince v. Massachusetts, 321 U.S. 158, 166 (1944). "The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition." Wisconsin v. Yoder, 406 U.S. 205, 232 (1972).

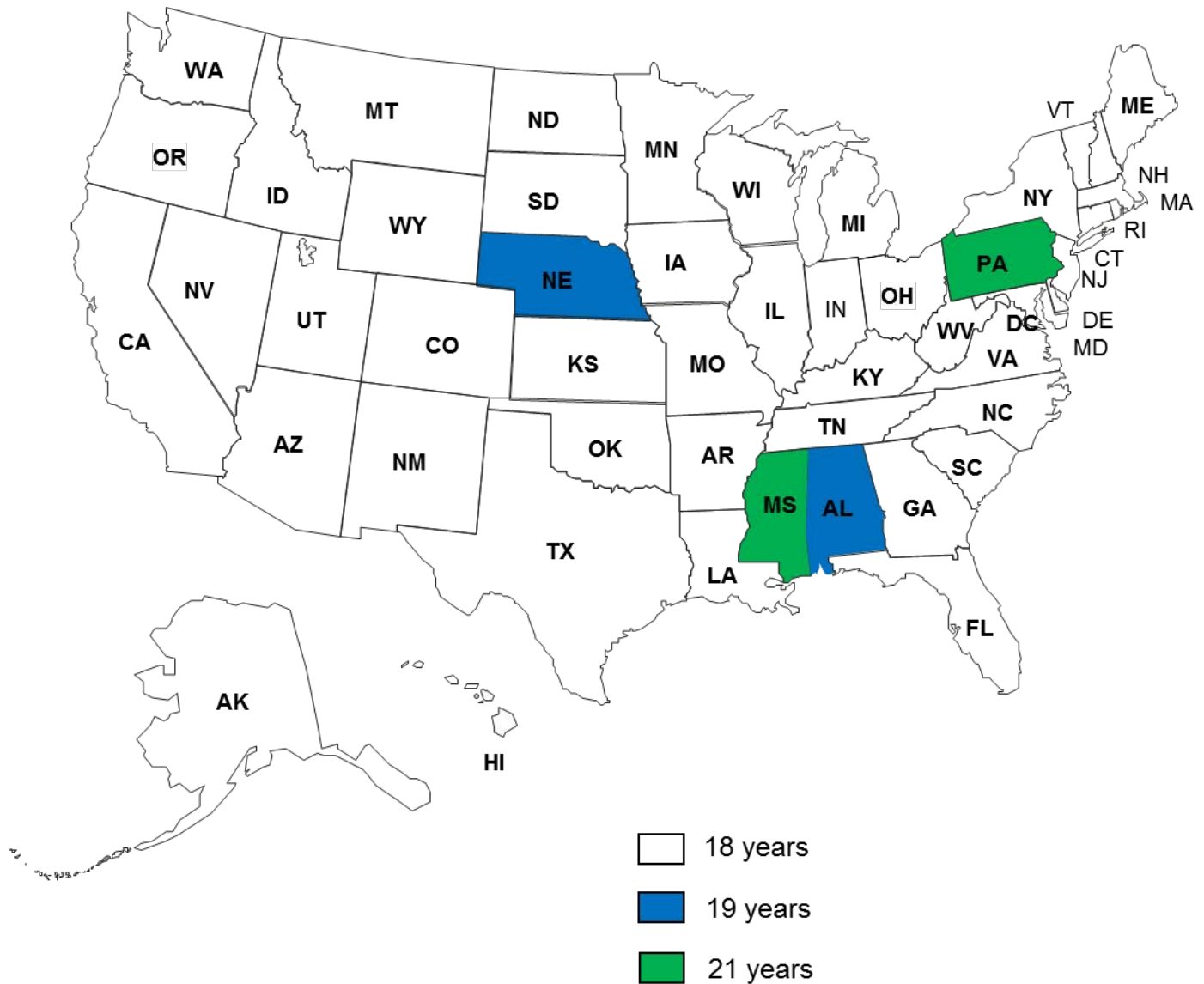
⁵ Prince, 321 U.S. at 166.

⁶ Bellotti v. Baird, 443 U.S. 622, 633 (1979).

⁷ Planned Parenthood of Missouri v. Danforth, 428 U.S. 52, 75 (1976).

consent for themselves in many circumstances. (See Figure 1 for age of majority by state.) These include minors who have been legally emancipated by a court. Criteria for emancipation vary from state to state but often include minors who are married, pregnant, parents, in the military, high-school graduates, or self-supporting and living apart from parents.⁸

Figure 1. Age of majority in years by state



⁸ Jennifer L. Rosato, Let's Get Real: Quilting A Principled Approach to Adolescent Empowerment in Health Care Decision-Making, 51 DEPAUL L. REV. 769, 776-77 (2002).

In some states, courts have also established through case law the right of “mature minors” to consent to certain types of health care; court decisions generally define “mature minors” as minors who are found to possess the intelligence and maturity to make a healthcare decision. When emergency treatment is required, parental consent is assumed and, therefore, explicit parental consent is not required to treat a minor.^{9 10} Further, the state is authorized to act to guard “the general interest in youth’s well being” and take action to protect the public’s health.¹¹

States have recognized that requiring parental involvement in certain sensitive health decisions may deter minors from seeking timely care and that the need to ensure access on the part of the minor outweighs the importance of parental involvement in the decision. Therefore, many states have enacted statutes expressly allowing minors to consent to certain types of care, including sexually transmitted infection (STI) testing and treatment, HIV testing and treatment, prenatal care, and contraceptive services.^{12 13}

A minor’s ability to consent to medical services may affect the success of a pharmacologic prevention measure for HIV, such as PrEP. Therefore, the current paper analyzed state laws associated with minor consent for medical care in order to explore whether state law would

⁹ American College of Obstetricians and Gynecologists. Confidentiality in adolescent health care. Washington, DC: ACOG; 2009. Available at:

[http://www.acog.org/~media/Departments/Adolescent%20Health%20Care/Teen%20Care%20Tool%20Kit/ACOG Confidentiality.pdf?dmc=1&ts=20120724T1526408587](http://www.acog.org/~media/Departments/Adolescent%20Health%20Care/Teen%20Care%20Tool%20Kit/ACOG%20Confidentiality.pdf?dmc=1&ts=20120724T1526408587). Retrieved 25 July 2012.

¹⁰ Boonstra H, Nash E. Minors and the right to consent to health care. *Guttmacher Rep Public Policy* 2000; 3(4):4–8.

¹¹ Prince, 321 U.S. at 166–67.

¹² American College of Obstetricians and Gynecologists. Confidentiality in adolescent health care. Washington, DC: ACOG; 2009. Available at:

[http://www.acog.org/~media/Departments/Adolescent%20Health%20Care/Teen%20Care%20Tool%20Kit/ACOG Confidentiality.pdf?dmc=1&ts=20120724T1526408587](http://www.acog.org/~media/Departments/Adolescent%20Health%20Care/Teen%20Care%20Tool%20Kit/ACOG%20Confidentiality.pdf?dmc=1&ts=20120724T1526408587). Retrieved 25 July 2012.

¹³ Boonstra H, Nash E. Minors and the right to consent to health care. *Guttmacher Rep Public Policy* 2000; 3(4):4–8.

affect adolescent access to PrEP and related HIV prevention methods without parental consent. For this article, the CDC, Office for State, Tribal, Local and Territorial Support (OSTLTS), Public Health Law Program (PHLP) surveyed laws affecting consent to general medical care, consent to STI prevention and testing, and consent to HIV testing and treatment.

Because the use of a pharmacologic intervention to prevent HIV infection is a new concept that has not been expressly addressed by state law, for the purposes of this legal survey, PHLP analogized PrEP to prevention measures for STIs. By analyzing minor access to STI prevention measures, this article contemplates how state law might treat minor access to PrEP. Additionally, because few jurisdictions allow minors to consent to preventive or prophylactic treatment for STIs, this article also explores what medical services states do allow minors to consent to, which is typically only the care covering the diagnosis and treatment of STIs.

Methods

The CDC's Division of HIV/AIDS Prevention requested a 50-state analysis of minor consent law and its implications for PrEP. PHLP staff used WestlawNext, a subscription-only online legal research service (www.westlaw.com), to systematically collect all statutes and regulations pertaining to mature minor doctrines and an adolescent's ability to consent to HIV diagnostic testing and treatment and STI diagnostic testing, treatment, and prevention. Staff first searched the statutory code and administrative regulations of each state individually using the search string "consent & (treat! prescribe diagnos! health medical counseling)" and then narrowed the results using "minor or adolescent."

Statutes and regulations from all states, as well as municipal regulations from the District of Columbia, were reviewed and relevant laws entered into a database organized by state. PHLP relied on state HIV, STI, and communicable (although some states use the alternate descriptions “contagious,” “infectious,” “dangerous,” and “reportable”) disease statutes to determine whether adolescents could potentially access PrEP without parental consent. Analysis was performed in 2012 on laws current as of December 31, 2011.

Public Health Law Program staff then compared the results to those described in *The Center for Adolescent Health & the Law’s State Minor Consent Laws: A Summary*,¹⁴ an extensive compilation of legal research on this topic that provided an excellent cross-check to ensure that all relevant statutes and regulations had been captured by PHLP’s original research. Staff analyzed statutes and regulations for each state and ascertained an adolescent’s ability to consent to medical care using generally accepted rules and conventions of statutory interpretation.¹⁵

Results

No state expressly prohibits minors’ access to PrEP or other HIV prevention methods. Forty-six states and the District of Columbia explicitly allow minors with certain status exceptions to consent to medical care for themselves. These exceptions vary by state, but the most common exceptions are for a minor who is emancipated by court order, serving on active duty in the military, married, a parent, or a high-school graduate. (In order to be emancipated by court order,

¹⁴ English A, Bass L, Boyle AD, Eshragh F. *State Minor Consent Laws: A Summary*. Third Edition. Chapel Hill, NC: Center for Adolescent Health & the Law (2010). Available at: <http://www.cahl.org/web/index.php/state-minor-consent-laws-a-summary-third-edition/>.

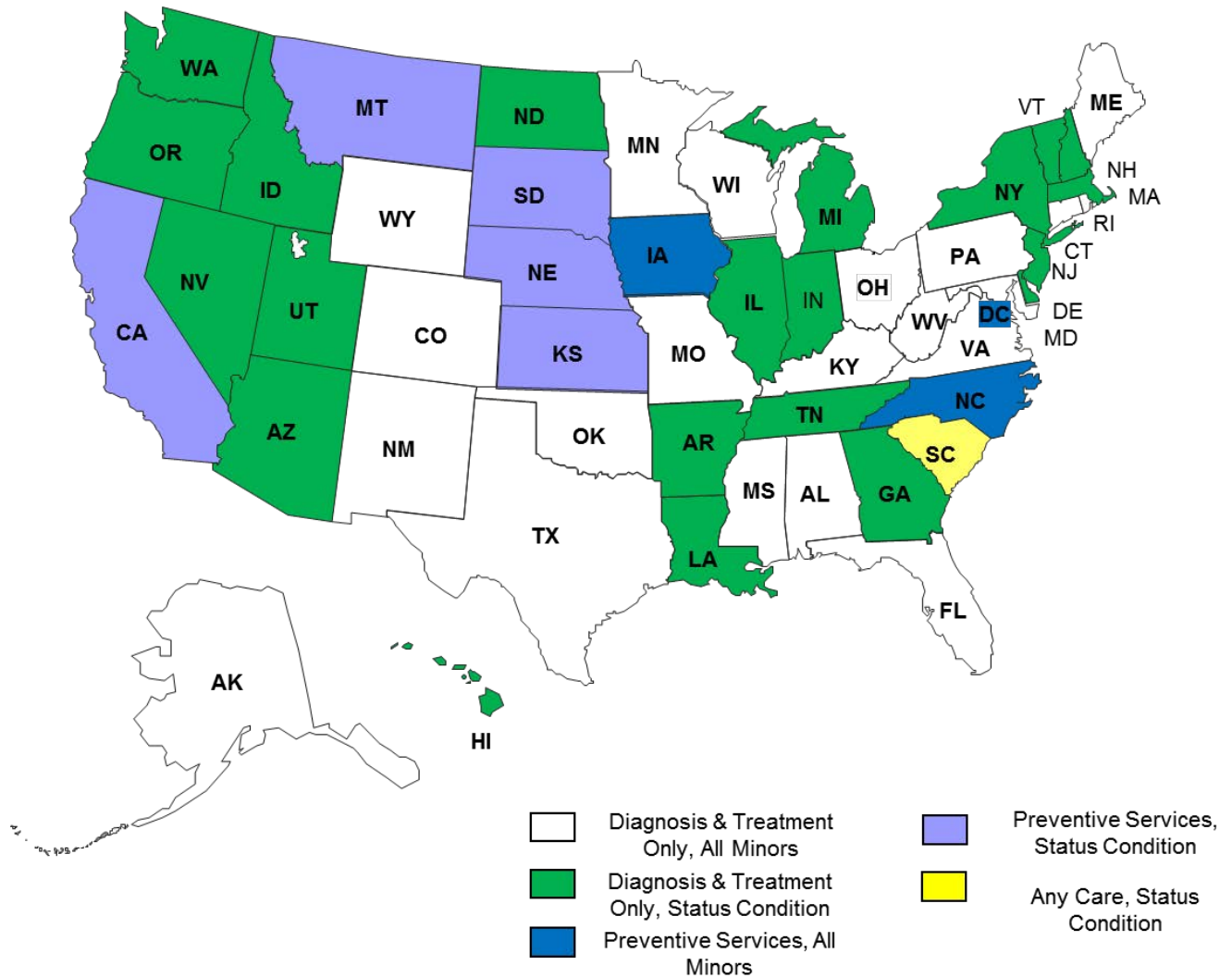
¹⁵ See Kim Y. *Statutory Interpretation: General Principles and Recent Trends*. Congressional Research Service (August 31, 2008). Available at: <http://www.fas.org/sgp/crs/misc/97-589.pdf>.

states generally require minors to fulfill other specific conditions, such as living separate and apart from their parents and being financially self-sufficient.) Only New Hampshire, Rhode Island, Tennessee, and Wisconsin do not have statutes or regulations allowing certain minors to consent to medical care based on their status.

All jurisdictions expressly allow some minors to consent to medical care for the diagnosis or treatment of STIs. However, the criteria under which minors may consent vary (Figure 2).

Twenty-one states and the District of Columbia allow all minors to consent for diagnosis or treatment of STIs, while another 21 states either impose age restrictions or allow only those who may have been exposed to an STI to consent.

Figure 2. Minor’s capacity to consent to sexually transmitted infection services by type of service and minor status



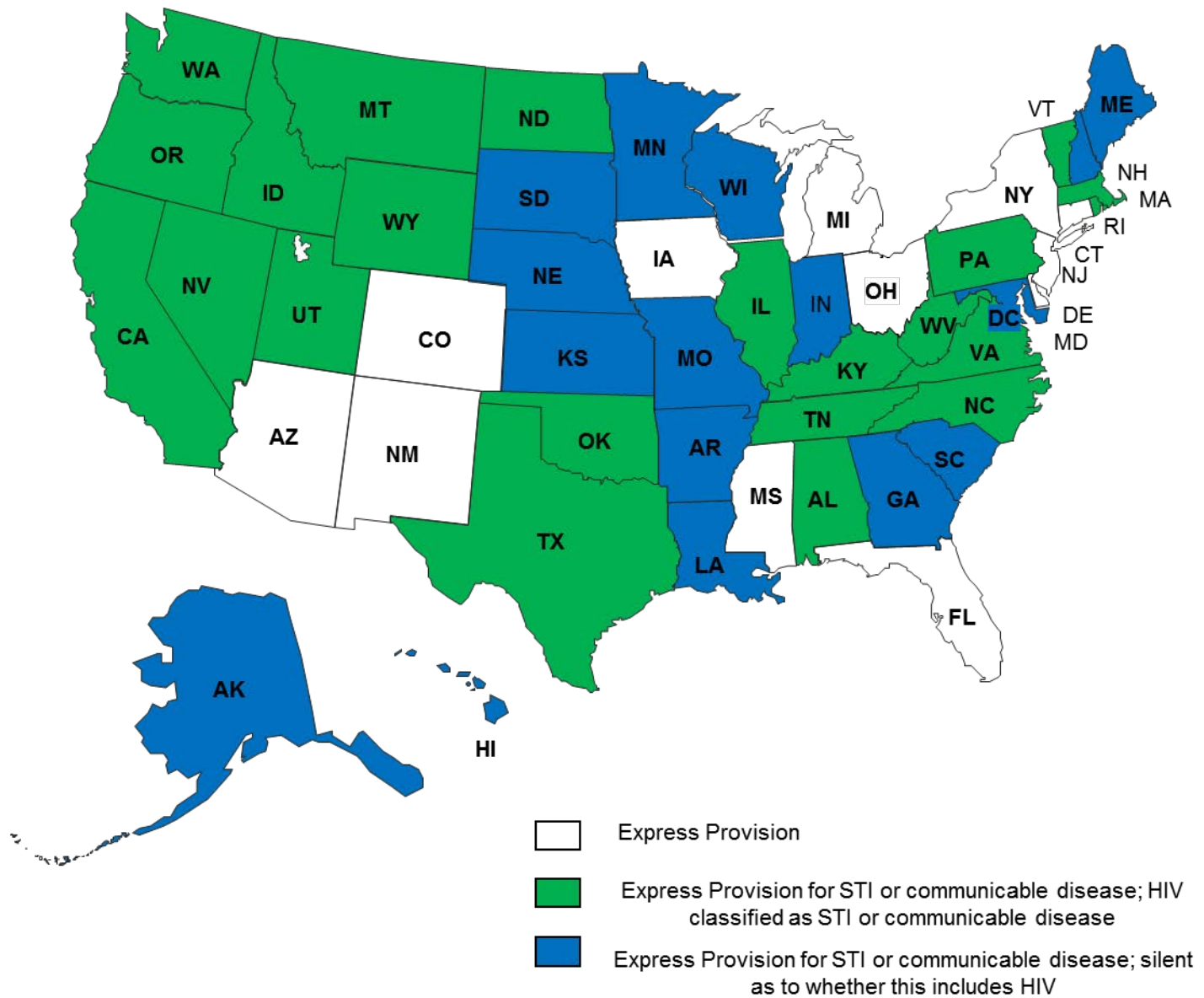
Only seven states (California, Iowa, Kansas, Montana, Nebraska, North Carolina, and South Dakota) and the District of Columbia expressly allow minors to consent to preventive or prophylactic services for STI. Preventive services may include counseling, male and female condoms, diaphragms, vaccination, and other methods, but what is allowable may vary from state to state. Of these seven states, four (Kansas, Montana, Nebraska, and South Dakota) allow prophylactic treatment only if a minor is suspected of coming into contact with an STI.

Additionally, one state—California—adds an age restriction, allowing only minors who are aged

≥12 years to consent to preventive care for an STI. Two other states (Iowa and North Carolina) and the District of Columbia do not place any conditions on a minor's access to STI preventive care, whereas South Carolina allows a minor who is aged ≥16 years to consent to medical services that a provider deems necessary.

The Public Health Law Program grouped laws regarding minor consent to HIV testing and treatment into three categories: (1) jurisdictions that expressly allow minors to consent to HIV diagnostic testing or treatment; (2) jurisdictions that expressly allow minors to consent to STI or communicable disease diagnostic testing or treatment and further specify that HIV is a communicable disease or STI; and (3) jurisdictions that expressly allow minors to consent to STI diagnostic testing or treatment but are silent as to whether HIV is a communicable disease or STI, and have no express provisions for minor consent to HIV diagnostic testing or treatment (Figure 3).

Figure 3. Minor capacity to consent to HIV services by type of service



Twelve states (Arizona, Colorado, Connecticut, Delaware, Florida, Iowa, Michigan, Mississippi, New Jersey, New Mexico, New York, and Ohio) expressly allow minors to consent to HIV testing or treatment. Of these, five states (Arizona, Mississippi, New Mexico, New York, and Ohio) allow minors to consent to HIV testing, but not treatment. Two additional states (Delaware

and Florida) have an express provision only for HIV testing, but minors can consent to HIV treatment under broader communicable disease provisions.

Twenty-two states (Alabama, California, Idaho, Illinois, Kentucky, Massachusetts, Montana, Nevada, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wyoming) allow minors to consent to testing or treatment for STIs or communicable diseases and classify HIV as either an STI or communicable disease. Consequently, minors in these states may consent to HIV testing or treatment under those STI or communicable disease provisions. Sixteen states and the District of Columbia allow minors to consent to STI testing and treatment, but they neither have an express HIV provision nor classify HIV as an STI or communicable disease. Among these states, South Carolina allows minors aged ≥ 16 years to consent to any care a provider deems necessary, and Arkansas allows minors of sufficient intelligence to consent to any medical treatment or procedure.

Discussion

A state may allow minors to consent for themselves to a particular medical service if there is a substantial interest in ensuring access to that service. Preventing HIV infection is an important public policy goal of states and sufficiently compelling that state courts have ruled that minors may access prevention methods such as condoms without parental consent.¹⁶ However, allowing

¹⁶ “Plaintiffs, however, cannot show either that the condom program endangers children or that the defendants had the requisite intent. If in-school distribution of condoms increases sexual activity, Plaintiffs might show endangerment. But Plaintiffs have provided no evidence linking condom distribution to increased sexual activity. Further, while improper use of condoms can be dangerous, failing to use condoms puts sexually active children at even greater risk. If anything, the danger to the children would be increased were this condom program quashed.”

minors access to condoms without parental consent is arguably distinguishable from allowing minors to receive PrEP without parental consent because condoms are a substantially less invasive method of prevention than antiretroviral medication. (Case law on minors' access to condoms without parental consent merits further exploration as it pertains to PrEP.) Additionally, taking antiretroviral medication carries a small risk of side effects or toxicities, whereas this risk is rare for condoms. Even so, given the serious consequences of HIV infection, the state has a strong interest in preventing new infections among minors as well as adults.

Another factor affecting adolescent access to PrEP is the issue of prophylaxis itself. Many state statutes and regulations make a substantial distinction between allowing minors to consent to preventive medical services and allowing minors to consent to medical treatment. At least one district court has held that condoms are a preventive measure, rather than a medical treatment, because they “are non-invasive, are not used to diagnose or cure disease, and do not require medical training or supervision for their use.”¹⁷ However, such a holding may not extend to PrEP, as the medication must be ingested and does require prescription and medical supervision for safe use. Therefore, states will find it arguably more difficult to draw an analogy between PrEP and condom distribution.

But although the use of antiretrovirals in PrEP is by definition preventive medical care, these same antiretrovirals are standard treatment for individuals who already have HIV infection.

Although most states allow minors to consent to medical treatment for STIs other than HIV infection, this exception is typically for adolescents who have actually been diagnosed with an

Parents United for Better Sch., Inc. v. Sch. Dist. of Philadelphia Bd. of Educ., 978 F. Supp. 197, 212 (E.D. Pa. 1997) *aff'd*, Parents United For Better Sch., Inc. v. Sch. Dist. of Philadelphia Bd. of Educ., 148 F.3d 260 (3d Cir. 1998).

¹⁷ Parents United for Better Sch., Inc., 978 F. Supp. at 207.

STI. Indeed, in many states, only adolescents who have reason to believe they have been exposed to an STI are allowed to request STI testing without parental consent. This distinction between medical treatment for a diagnosed health condition and a clinical preventive measure is crucial, and a provider's ability to prescribe PrEP to adolescents under current law may hinge on whether PrEP is determined to be more analogous to a preventive or a treatment measure.

Although no law expressly prohibits the use of PrEP in any jurisdiction, it may be permitted by implication for adolescents in the eight jurisdictions that allow minors to consent to STI preventive care, since HIV can be considered an STI. In the remaining 43 jurisdictions, minors' access to PrEP may rest on whether "treatment" is defined broadly or narrowly. For example, Mosby's Medical Dictionary defines treatment broadly as "the care and management of a patient to combat, ameliorate, or prevent a disease, disorder, or injury," encompassing both preventive and therapeutic care.¹⁸ Conversely, Stedman's Medical Dictionary defines treatment as the "medical or surgical management" of a patient, seeming to limit treatment to only therapeutic care.¹⁹

State statutes and regulations do not provide a uniform legal definition of treatment. Therefore, whether a healthcare practitioner prescribes PrEP to a minor at risk for HIV infection may depend on each state's interpretation of the term treatment. If a state seeks to amend its laws to provide PrEP to minors without requiring parental consent, the new language should explicitly permit access to STI preventive care instead of merely authorizing minors to consent to STI diagnostic and treatment care. For example, California amended the minor consent provision of

¹⁸ Mosby's Medical Dictionary, 8th Edition. 2009, Elsevier.

¹⁹ Stedman's medical dictionary. Treatment: Retrieved September 26, 2012, from: <http://dictionary.reference.com/browse/treatment>.

its Family Code in the 2011 legislative session to allow minors aged ≥ 12 years to “consent to medical care related to the prevention of a sexually transmitted disease.”²⁰

Another avenue through which minors may be able to access PrEP is the Title X Family Planning Program. Title X is a federal grant program created for the express purpose of “providing individuals with comprehensive family planning and related preventive health services.”²¹ Under federal regulations, family planning clinics receiving Title X funds must provide services to anyone, male or female, regardless of age and must maintain confidentiality. Although the federal regulations encourage minor patients to involve parents in their family planning decisions, a federal court held that parental notification cannot be required and, following this line of reasoning, clinics receiving Title X funds cannot require parental consent.²²

In addition to family planning services, Title X–funded clinics provide many other preventive health services, including pregnancy diagnosis and counseling, breast and cervical cancer screenings, and STI education, counseling, testing, and referral (www.hhs.gov/opa/title-x-family-planning/). Title X–funded clinics also must provide “at a minimum, education about HIV infection and AIDS, information on risks and infection prevention, and referral services” (www.hhs.gov/opa/title-x-family-planning/). Moreover, Title X–funded clinics have the option to “provide HIV risk assessment, counseling and testing by specially trained staff.” If a clinic does not offer these optional services, it must provide clients “with a list of health care providers

²⁰ Cal. Fam. Code § 6926

²¹ Title X Family Planning, available at <http://www.hhs.gov/opa/title-x-family-planning>.

²² 42 U.S.C.A. § 300; *Planned Parenthood Fed'n of Am., Inc. v. Heckler*, 712 F.2d 650, 656-661 (D.C. Cir. 1983). The Medicaid Program also requires family planning services be kept confidential.

who can provide these services.”²³ Because these family planning clinics are bound by federal regulations regarding a minor’s ability to consent, some adolescents could access PrEP at Title X–supported clinics, in theory. However, limited funding means that many Title X clinics are unable to provide HIV services beyond the required minimum.²⁴

Limitations

This review has two key limitations. First, for clarity and efficiency, PHLP staff narrowed analysis to state statutes and regulations and did not comprehensively review case law, professional licensing board opinions or rules, and other enforcement guidance, such as attorney general opinions, that could affect the provision of PrEP to minors in many states. Second, this analysis examines the law on its face only and does not examine how the law is applied. Because the laws of most states are silent on the issue of preventive treatment of STI, a physician may exercise her discretion to treat an at-risk adolescent minor by prescribing PrEP. This discretionary prescription could alter significantly the availability of PrEP to minors from what state law, or gaps in the law, suggest.

Conclusion

Clinical trials have demonstrated that PrEP is a potentially useful public health prevention measure for HIV, but the findings from this study indicate that minor access to PrEP without parental consent is unclear. Further work is needed to evaluate case law and enforcement

²³ DHHS. Program guidelines for project grants for family planning services. DHHS, 2001. www.hhs.gov/opa/pdfs/2001-ofp-guidelines-complete.pdf.

²⁴ DHHS, Office of Population Affairs. HIV prevention and integration in family planning. www.hhs.gov/opa/initiatives/hivprevention/index.html.

guidance, and to establish each state's definition of the term "treatment" as it may relate to the provision of clinical interventions for the prevention of HIV infection.

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