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PREP AND OUR YOUTH: IMPLICATIONS IN LAW AND POLICY

JASON POTTER BURDA*

Abstract

Truvada[®], an antiretroviral medication originally approved to treat human immunodeficiency virus (HIV), is the first drug to receive FDA approval for use by HIV-negative individuals to actually prevent infection. The prophylactic use of an antiretroviral such as Truvada is a pharmacological prevention method called “HIV pre-exposure prophylaxis” (or “PrEP”). With an efficacy of over ninety percent when used as prescribed, Truvada as PrEP has been embraced by the public health community, and implementation is under way across the United States. Truvada as PrEP is currently indicated for adult use only, but it may also be prescribed off-label to at-risk youth.

In this Article, I draw upon public health, neurodevelopmental, and psychosocial research to argue that PrEP is a necessary tool in the fight against HIV among youth. Thus, exploring the challenges of delivering PrEP to at-risk youth is essential. As a general rule, states mandate the involvement of parental figures in the healthcare of minors. However, recognizing that parental involvement in sensitive matters such as sexually transmitted infection (STI) treatment is a barrier to reaching youth, legislators have crafted limited exceptions to this rule. With the goal of locating inroads to confidential PrEP access in these exceptions, I survey STI, emancipation, and emergency consent laws, develop frameworks for navigating them, and suggest that STI laws offer the most promise of offering confidential PrEP access. Further, I posit that providing PrEP at clinics receiving Title X family planning funds, which must offer confidential services to youth, may be a national means of achieving that end. Yet guaranteeing accessibility is only one piece of the delivery puzzle; guaranteeing acceptability is a second. As such, I propose the addition of PrEP to sexual education programming funded by grants from the ACA’s Personal Responsibility Education Program, which would ensure that curricula include PrEP alongside more established prevention methods such as condoms. Overcoming these barriers will pave the way for rapid uptake of future HIV prevention innovations for and among the most vulnerable: our youth.

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INTRODUCTION

Of the nearly 50,000 new HIV infections in the United States every year, the United States Centers for Disease Control and Prevention (CDC) estimates that, as of 2013, over twenty percent of those infections were among youth.¹ That year, the CDC estimated that 62,400 youth had HIV in the United States, and over half of those youth (n=32,000) were living with an undiagnosed infection.² These data reveal that the HIV crisis among youth is both significant and stealthy. Yet the obstacles to effective HIV prevention among youth are growing. Temporally removed from the AIDS crisis and less fearful of HIV because treatment has advanced so rapidly and so publicly, today's youth are increasingly resistant to traditional HIV prevention models rooted in behavioral modification, risk reduction, and condom education. In short, youth in the United States are on a collision course with HIV, and incorporating new, sustainable prevention modalities as part of a multifaceted HIV prevention approach will be necessary to avoid greater impact.

HIV pre-exposure prophylaxis (PrEP) has proved a necessary tool in the at-risk adult population, and implementation is underway on a broad scale. PrEP is a pharmacological HIV prevention modality³ involving prescription of antiretroviral drugs (ARVs), traditionally used to treat those living with HIV, to at-risk HIV-negative individuals to avoid infection. The only ARV currently approved for a PrEP indication is a daily dose of Truvada, manufactured exclusively by Gilead Sciences and available by prescription.⁴

1 *HIV Among Youth*, CTNS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/hiv/group/age/youth> [<http://perma.cc/3UBC-5V2L>] (last visited June 30, 2015) (noting that, of the 47,352 people diagnosed during 2013, twenty-one percent (n=9,961) were youth ages thirteen through twenty-four). As of this writing, 2013 data is the most recent available pertaining to HIV among youth. For the purpose of data collection, the CDC defines "youth" as young people between thirteen and twenty-four years of age.

2 *See id.*

3 Pharmacological prevention is one of several modalities under the broader umbrella of "biomedical HIV prevention." In this Article, biomedical HIV prevention includes: (1) pharmacological HIV prevention; (2) over-the-counter barrier methods such as male and female condoms, dental dams, and diaphragms; and (3) medical procedures such as male circumcision. *See* Jason Potter Burda, *When Condoms Fail: Making Room Under the ACA Blanket for PrEP HIV Prevention*, 52 SAN DIEGO L. REV. 171, 174 n.18, 176 n.28, 182 (2015), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2489457 [<http://perma.cc/2RQX-9LLS>]; Kristen Underhill, *Paying for Prevention: Challenges to Health Insurance Coverage for Biomedical HIV Prevention in the United States*, 38 AM. J.L. & MED. 607, 610 (2012); Gita Ramjee & Claire Whitaker, *Biomedical HIV Prevention*, in BIOMEDICAL ENGINEERING - FROM THEORY TO APPLICATIONS 23 (Reza Fazel-Rezai ed., 2011), <http://cdn.intechweb.org/pdfs/18622.pdf> [<http://perma.cc/4TLN-Y4Y7>].

4 *Pre-Exposure Prophylaxis (PrEP)*, AIDS.GOV, <https://www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/pre-exposure-prophylaxis> [<http://perma.cc/C6QQ-K4DP>] (last updated Nov. 25, 2015).

With an effectiveness of over ninety percent in the adult population when taken as prescribed, PrEP has received widespread federal and state endorsements. There is some indication that recent HIV prevention initiatives incorporating PrEP may be working to curb infections among adults.⁵ However, given the significant rate of HIV infection among youth, attention has begun to shift to operationalizing PrEP for those youth whose behavior or circumstances puts them at high risk of contracting HIV (herein, “at risk” or “at-risk youth”).

Experts are only beginning to understand the magnitude of the challenges facing those seeking to deliver PrEP to youth,⁶ but the same base obstacles facing those seeking wider implementation of PrEP among adults also face those seeking to operationalize PrEP for youth. In my previous article, *When Condoms Fail*, I identified two hurdles to implementation of PrEP among adults: accessibility and acceptability.⁷ PrEP must be accessible to those most at risk of HIV infection. As such, the therapy must be “procurable with little complication or delay.”⁸ Furthermore, PrEP must be acceptable to those who stand to benefit from it. This involves eliminating the stigma that attaches to those who use it. For youth, these challenges have added complexity and an unmistakably legal dimension.

Pursuant to laws in every United States jurisdiction, the majority of youth in the United States from ages thirteen to eighteen, a critical population in the fight against HIV, are unable to operate independently of their parents, guardians, and other adult caregivers⁹ in most healthcare decisions. Parental involvement and consent, though appropriate in many circumstances, can result in delays in care, breaches of confidentiality, and the eschewing

5 See, e.g., Liz Highleyman, *San Francisco Sees Decline in New HIV Infections and Deaths of People with HIV*, HIV & HEPATITIS (July 14, 2015), <http://hivandhepatitis.com/hiv-aids/hiv-aids-topics/hiv-treatment/5283-san-francisco-sees-declines-in-new-hiv-infections-and-deaths-of-people-with-hiv-2> [http://perma.cc/KC84-Y3LM].

6 As of this writing, two academic pieces exploring PrEP for youth have been published in medical and public health journals. See Lindsay Culp & Lisa Caucci, *State Adolescent Consent Laws and Implications for HIV Pre-Exposure Prophylaxis*, 44 AM. J. PREVENTIVE MED. 119 (2013); Quianta L. Moore et al., *Legal Barriers to Adolescent Participation in Research About HIV and Other Sexually Transmitted Diseases*, 106 AM. J. PUB. HEALTH 40 (2016).

7 See Burda, *supra* note 3, at 192–214.

8 See *id.* at 193.

9 In this Article, the terms “adult caregiver,” “parent,” and “guardian” describe an adult charged with legal decision-making capacity for a minor; these terms should be interpreted as including, as the case may be, non-parent adults such as blood and non-blood related relatives, foster parents, conservators, and the state.

of care entirely in the context of sexual healthcare. For example, approximately half of all female adolescents would prefer to forego sexual healthcare services than permit their providers¹⁰ to notify a parent of their decision to take birth control.¹¹ Moreover, youth whose circumstances put them at risk of HIV infection—such as detained youth, homeless or unstably housed youth, young men who have sex with men, serodiscordant youth couples, and youth who share syringes—tend to eschew healthcare at a higher rate than average.¹² Thus, in the area of HIV prevention advocacy and policy, developing sustainable solutions to reach at-risk youth without compromising their privacy has become a priority. Developing such solutions will require not just clever public health advocacy and policymaking, but also clever lawyering and lawmaking.

In this Article, I study PrEP as a vehicle for exploring the major challenges to operationalizing pharmacological HIV prevention for at-risk youth. In Part I, I review adolescent¹³ psychosocial and neurodevelopmental science to argue that traditional models of HIV prevention, without the incorporation of new, sustainable solutions, have a high likelihood of failure among the youth population and have, in fact, failed to curb HIV incidence among youth. As such, PrEP is a much-needed addition to the youth HIV prevention toolbox. In Part II, I focus on the accessibility challenge of operationalizing PrEP for youth presented by parental consent and notification requirements, and review state exceptions to the general rule that minors may not consent to their own healthcare. I argue that the surest avenue to operationalizing PrEP for unaccompanied, self-consenting minors without breaching confidentiality is by concentrating on STI consent laws at the state level, for which I conduct a comprehensive survey, and on clinics receiving Title X

10 In this Article, the term “provider” describes an individual (such as a physician or advanced practice nurse) or entity (such as a health center or clinic) furnishing healthcare services.

11 N. LABOR ET AL., N.Y.C. DEP’T. OF HEALTH AND MENTAL HYGIENE, HEALTHY TEENS INITIATIVE: SEVEN STEPS TO COMPREHENSIVE SEXUAL AND REPRODUCTIVE HEALTH CARE FOR ADOLESCENTS IN NEW YORK CITY 1 (2006), <http://www.nyc.gov/html/doh/downloads/pdf/ms/ms-hti-guide.pdf> [<http://perma.cc/9BM3-HPAH>] (citing U.S. DEP’T OF HEALTH & HUM. SERVS., HEALTHY PEOPLE 2010: UNDERSTANDING AND IMPROVING HEALTH AND OBJECTIVES FOR IMPROVING HEALTH (2d ed. 2000)).

12 See Paul Arshagouni, *But I’m an Adult Now . . . Sort Of: Adolescent Consent in Health Care Decision-Making and the Adolescent Brain*, 9 J. HEALTH CARE L. & POL’Y 315, 322 (2006) (citing Carol A. Ford et al., *Foregone Health Care Among Adolescents*, 282 JAMA 2227, 2230 tbl.2, 2231 (1999)).

13 In this Article, I do not use the terms “adolescent,” “minor,” and “youth” interchangeably. I use the term “adolescent” in the context of neurodevelopmental, psychosocial, or other research focusing on the period of adolescence, principally in Part I. I use the term “minor” in the context of state minor consent and parental notification laws, principally in Part II, to reference individuals under the age of majority howsoever defined by state law. I use the term “youth” at all other times to reference those individuals less than eighteen years of age.

funding, at the federal level. In Part III, I focus on the acceptability challenge. I argue that local, state, and federal governments play a role in ensuring that sexual education curricula address the complete spectrum of available HIV prevention methods—including PrEP—so that, in their providers’ offices, at-risk minors are familiar with PrEP therapy, view it as a legitimate prevention modality, and have the knowledge to make reasoned decisions about which prevention options work for them.

I. The Necessity of PrEP

“If there is anything that can be safely said about what is new in the minds of adolescents, it is that they . . . have sex on their minds.”

—Carol Gilligan and Lawrence Kohlberg¹⁴

Adolescence, life’s second stage marked by the onset of puberty,¹⁵ is a “transitional social category,”¹⁶ a time of significant physiological, neurological, and psychosocial development.¹⁷ Alongside the physical maturation of secondary sex characteristics, adolescents experience increased “neurological plasticity,” where the mind develops increased cognitive abilities. Adolescence is also marked by vigorous behavioral changes,¹⁸ including an increase in awareness of—indeed, fixation on—peer relationships, and in particular the sexual aspect of those relationships.¹⁹ At the same time, adolescents grow

14 Lawrence Kohlberg & Carol Gilligan, *The Adolescent as a Philosopher: The Discovery of the Self in a Post-Conventional World*, in TWELVE TO SIXTEEN: EARLY ADOLESCENCE 1051, 1060 (Jerome Kagan & Robert Coles eds., 1972). See also LINDA PATIA SPEAR, *THE BEHAVIORAL NEUROSCIENCE OF ADOLESCENCE* 3 (2010) (noting that “[a]dolescence is a time of transitions: from childhood to adulthood, from dependence to (relative) independence, from a nonsexual state to sexual maturity”).

15 See Jennifer Ann Drobac, “*Developing Capacity*”: Adolescent “Consent” at Work, at Law, and in the Science of the Mind, 10 U.C. DAVIS J. JUV. L. & POL’Y 1, 11 (2004); Arshagouni, *supra* note 12, at 318. See also SPEAR, *supra* note 14, at 5 (noting that adolescence, “the entire transition from childhood to adulthood,” and puberty, “the more restricted time interval associated with the hormonal and physiological changes of sexual maturation,” are distinct terms that should not be used synonymously).

16 NICOLE VITELLONE, *OBJECT MATTERS: CONDOMS, ADOLESCENCE AND TIME* 13 (2008).

17 See Jennifer Ann Drobac, *A Bee Line in the Wrong Direction: Science, Teenagers, and the Sting to “The Age of Consent,”* 20 J.L. & POL’Y 63, 66 (2011) (citing SPEAR, *supra* note 14, at 5).

18 Jay N. Giedd, *The Digital Revolution and Adolescent Brain Development*, 51 J. ADOLESCENT HEALTH 101 (2012).

19 Roxanne Mykitiuk et al., *Legal Dimensions of Adolescent Sexuality*, 26 J. OBSTETRICS & GYNAECOLOGY

more removed from parents and other authority figures.²⁰ At its crux, adolescence is a drive toward autonomy replete with personal and inter-personal growth.²¹

This drive toward autonomy during adolescence can engender life-threatening consequences.²² Mortality rates drastically increase during adolescence,²³ and the behavior causally related to this mortality increase is risk-taking.²⁴ Concentrating primarily on adolescent sexual risk-taking, the most concerning period for such behavior is mid-adolescence, specifically between the ages of fifteen and seventeen.²⁵ This age span is an especially important time for preventive sexual healthcare and harm reduction. According to Dr. Laurence Steinberg:

[R]eward sensitivity, preference for immediate rewards, sensation-seeking, and a greater focus on the rewards of a risky choice all increase

991 (2004).

20 Giedd, *supra* note 18, at 101.

21 LISA J. CROCKETT & ANN C. CROUTER, *PATHWAYS THROUGH ADOLESCENCE: INDIVIDUAL DEVELOPMENT IN RELATION TO SOCIAL CONTEXTS 2* (1995).

22 See generally D. Baumrind, *A Developmental Perspective on Adolescent Risk Taking in Contemporary America*, in *HANDBOOK OF ADOLESCENT SOCIAL BEHAVIOR AND HEALTH* 98 (Ralph J. DiClemente et al. eds., 1987) (observing that, “[b]y definition, a transition period such as adolescence is disequilibrating and disrupting and thus replete with opportunities that are both dangerous and growth enhancing”). See also SPEAR, *supra* note 14, at 130.

23 Charles E. Irwin & Susan G. Millstein, *Risk-Taking Behaviors and Biopsychosocial Development During Adolescence*, in *EMOTION, COGNITION, HEALTH, AND DEVELOPMENT IN CHILDREN AND ADOLESCENTS* 75, 76–77 (Elizabeth J. Susman et al. eds., 2014).

24 *Id.* In studies of adolescent risk-taking, researchers have characterized the following behaviors as risk-taking activities: criminal activity, self-harm, thrill sports, sexual activity, and illicit drug use. See *id.* at 76. This Article focuses on the major behavioral risk-taking activities attendant to HIV infection among adolescents: sexual activity and, to a lesser extent as it is relevant within the Article, illicit drug use (particularly injection drug use).

25 Laurence Steinberg, *A Social Neuroscience Perspective on Adolescent Risk-Taking*, 28 *DEVELOPMENTAL REV.* 78 (2008), <http://www.sciencedirect.com/science/article/pii/S0273229707000536> [<http://perma.cc/494V-69UG>] [hereinafter Steinberg, *Neuroscience Perspective*]. It is generally understood that there are three stages of adolescent social and psychosocial development: pre-adolescence, mid-adolescence, and emerging or young adulthood. Bret J. Rudy, *Adolescents and HIV*, in *TEXTBOOK OF PEDIATRIC HIV CARE* 197, 198 (Steven L. Zeichner & Jennifer S. Read eds., 2005). The first stage, early adolescence, is roughly from ages twelve through fourteen. See *id.* The second stage, or mid-adolescence, is roughly between the ages of fifteen and seventeen. See *id.* The final stage, or late adolescence, is roughly between ages eighteen and nineteen. See *id.*

between pre-adolescence and mid-adolescence, peak between ages 15 and 17, and then decline. In contrast, controlling impulses, planning ahead, and resisting peer influence all increase gradually from pre-adolescence through late adolescence, and in some instances, into early adulthood.²⁶

As such, my primary focus in this Article is the period of mid-adolescence, a time of unavoidable propensity for HIV-associated risk behaviors.

In this section, I review the science of adolescent development to argue that normative, biologically driven increases in adolescent risk-taking, sensation-seeking, and peer affiliation demonstrate the need to develop an HIV prevention safety net, and to clear the social and legal barriers to delivery. I then argue that traditional methods of HIV prevention among youth have been, and are likely to continue to be, ineffective without the addition of a pharmacological HIV prevention safety net.

A. The Science of Adolescent Risk

During adolescence, there is a conflict between sensation-seeking and an adolescent's ability to regulate his or her own behavior.²⁷ Dr. Laurence Steinberg notes that, as a result of brain maturation during adolescence, "changes . . . in the brain's socio-emotional system lead[] to increased reward-seeking, especially in the presence of peers, fueled mainly by a dramatic remodeling of the brain's dopaminergic system."²⁸ During this time, the desire for novelty and sensation seeking increases "dramatically," yet an adolescent's ability to "turn off" those impulses is not yet fully developed.²⁹ It is only in adulthood that risk-taking then tends to decline.³⁰ According to Dr. Steinberg, these changes "make mid-adolescence a time of heightened vulnerability to risky and reckless behavior."³¹ Importantly, Steinberg

26 Laurence Steinberg, *Should the Science of Adolescent Brain Development Inform Public Policy?*, 28:3 ISSUES IN SCI. & TECH. (2012), <http://issues.org/28-3/Steinberg> [<http://perma.cc/U9XP-MXVV>].

27 See Claudia Dreifus, *Developmental Psychologist Says Teenagers Are Different: A Conversation with Laurence Steinberg*, N.Y. TIMES, Nov. 30, 2009, <http://nyti.ms/1MGv1Qo> [<http://perma.cc/ZKY5-GY24>].

28 Steinberg, *Neuroscience Perspective*, *supra* note 25, at 78.

29 Laurence Steinberg, *Risk Taking in Adolescence: New Perspectives from Brain and Behavior Science*, 16 CURRENT DIRECTIONS PSYCH. SCI. 55, 56 (2007) [hereinafter Steinberg, *New Perspectives*]; see also Dreifus, *supra* note 27.

30 See Steinberg, *New Perspectives*, *supra* note 29, at 56.

31 Steinberg, *Neuroscience Perspective*, *supra* note 25, at 78.

posits that the biologically-driven increase in risk-taking behavior in adolescence means that modulating adolescent risk-taking is “unlikely to be remedied through educational interventions designed to change adolescents’ perception, appraisal, or understanding of risk.”³² In fact, scientists suggest that harm reduction strategies that insure against the negative consequences of risk will be most effective in preventing those consequences when risk-taking activity occurs.³³ Examples of these strategies include oral contraception to prevent pregnancy and the human papillomavirus (HPV) vaccine to prevent transmission of the HPV.

Despite adolescent brain maturation that increases adolescent impulsivity and thrill-seeking tendencies, adolescents do not lack the essential qualities that allow them to make effective decisions about how to maximize their protection against certain important risks. Steinberg posits that adolescents likely have the cognitive ability needed to make some informed medical choices, especially when the decision requires adult consultation.³⁴ Although there is not extensive data about adolescent decision-making in the medical context,³⁵ behavioral data related to adolescent risk generally has implications in the context of adolescent harm reduction. For adolescents, “[s]uboptimal decisions typically occur in tasks with immediate reward conditions.”³⁶ In other words, in situations of immediate pleasure, adolescents display an impaired ability to make reasoned decisions.³⁷ In the context of harm reduction for adolescents, this suggests that, in conditions where an adolescent is faced with a decision immediately prior to gratification—such as whether to use a condom immediately before sex or whether to use a clean needle immediately before

32 Lawrence Steinberg, *Risk Taking in Adolescence: What Changes, and Why?*, 1021 ANN. N. Y. ACAD. SCI. 51 (2004), <http://www.ncbi.nlm.nih.gov/pubmed/15251873> [<http://perma.cc/LEE2-CEA6>] [hereinafter Steinberg, *What Changes, and Why?*]. See also SPEAR, *supra* note 14, at 154 (noting that “the emotional context of the moment may favor reactive, ‘hot cognitions’ rather than decisions based on rational, logic-based cognitive processing”).

33 See, e.g., Steinberg, *What Changes, and Why?*, *supra* note 32.

34 See Press Release, Am. Psychol. Assoc., While Adolescents May Reason as Well as Adults, Their Emotional Maturity Lags, Says New Research, American Psychological Assoc. (Oct. 7, 2009), <http://www.apa.org/news/press/releases/2009/10/teen-maturity.aspx> [<http://perma.cc/NNZ2-9UVB>].

35 See Irma M. Hein et al., *Why Is It Hard to Make Progress in Assessing Children’s Decision-making Competence?*, 16 BMC MED. ETHICS 1, 3 (2015), [<http://perma.cc/6SSG-Y5B2>].

36 Theresa Teslovich et al., *Adolescents Let Sufficient Evidence Accumulate Before Making a Decision When Large Incentives Are at Stake*, 17 DEV. SCI. 59, 60 (2014), https://www.simenlab.org/FinalPublications/TeslovichEtAl_desc12092.pdf [<https://perma.cc/WTA6-AQBL>].

37 *Id.*

injection—the adolescent is less capable of a reasoned decision. Stated another way, when an adolescent separates the decision about protection from the act of sex or injection, and instead makes harm reduction choices in the healthcare environment, the adolescent may have a greater capacity to evaluate his or her susceptibility to HIV-associated risks and rationally choose the prevention choices that work for him or her.

Against this backdrop, I examine HIV incidence among youth and traditional HIV prevention models among youth and introduce PrEP, a new pharmacological prevention method that comports with the foregoing scientific findings concerning adolescent risk-taking and reward sensitivity.

B. Youth HIV Risk

Given adolescent predisposition to risk and impaired decision-making skills in risk scenarios, it is unsurprising that youth account for a disproportionate amount of overall HIV incidence in the United States.³⁸ HIV affects a number of sub-populations of youth, and many at-risk youth straddle risk categories.

Those especially prone to HIV infection are young gay, bisexual, transgender, and questioning (GBTQ) youth, or using epidemiological terminology, those youth characterized as male who have sex with other youth characterized as male (YMSM).³⁹ Of the infections among young people, YMSM are “severely affected,”⁴⁰ accounting for the large majority of new infections.⁴¹ In 2010, according to the CDC, YMSM comprised

38 See Ctrs. for Disease Control & Prevention, *Vital Signs: HIV Infection, Testing, and Risk Behaviors Among Youths – United States*, 61(47) MORBIDITY & MORTALITY WKLY. REP'T 971, 971–96 (2012).

39 See *id.* For the purpose of this Article, the term YMSM includes any young man who has sex with another man; this risk group includes those who self-identify as homosexual, heterosexual, bisexual, questioning, and transgender. It is important to note that most HIV prevention studies aggregate YMSM and male-to-female transgender groups. This, of course, is problematic because “transgender” is an umbrella term that includes individuals who may identify as transgender, male, female, heterosexual, or homosexual, and does not indicate anything about their sexual practices. Conversely, the term YMSM indicates a specific sexual practice. Nonetheless, the CDC continues to aggregate the two groups for the purpose of data collection despite increasing calls to treat these groups as distinct.

40 Brian C. Thoma & David M. Huebner, *Parental Monitoring, Parent-Adolescent Communication About Sex, and Sexual Risk Among Young Men Who Have Sex with Men*, 18 AIDS & BEHAV. 1604, 1604 (2014), <http://link.springer.com/article/10.1007/s10461-014-0717-z> [<http://perma.cc/Q8ZC-QN3S>].

41 See *HIV Among Youth*, *supra* note 1.

approximately 19% of all new HIV infections and 72% of new infections among youth.⁴² This represented a 22% increase in infections from 2008 to 2010, making YMSM the only risk group to show a substantial rise in new HIV infections during that period.⁴³ The CDC's 2013 data—the most recent available as of this writing—is even more troubling. In 2013, YMSM accounted for approximately 93% of all HIV infections among youth ages thirteen to nineteen years old.⁴⁴ Within the YMSM population, HIV incidence is particularly concerning among African American YMSM ages thirteen through nineteen.⁴⁵ In this sub-group, HIV incidence rose 50% from 2006 to 2009.⁴⁶ These statistics illustrate that developing effective HIV prevention programs to target YMSM generally, and African American YMSM specifically, continues to be a challenge.

While most youth contract HIV as a result of activities attendant to sexual risk,⁴⁷ youth who inject drugs (IDU-youth) are also vulnerable to HIV infection if they share syringes.⁴⁸ Among youth, and especially among street-involved youth, injection drug use is a rising problem.⁴⁹ Injection drug use also increases sexual risk behavior,⁵⁰ which can also increase

42 *Id.*

43 *Id.* (n=7,200, n=8,800).

44 *HIV Surveillance—Adolescents and Young Adults*, CTNS. FOR DISEASE CONTROL & PREVENTION, <http://1.usa.gov/1Gjt1gz> [<http://perma.cc/D4DH-TG6D>] (last visited May 19, 2015) [hereinafter *CDC Surveillance Slideshow*]. In 2013, in the United States among young adult males ages thirteen through nineteen, 92.6% of infections (n=1,441) were attributed to MSM sexual contact, 1.4% of infections (n=21) were attributed to injection drug use, 1.8% of infections (n=28) were attributed to both MSM sexual contact and injection drug use, 3.3% of infections (n=51) were attributed to heterosexual sexual contact, and .9% of infections (n=15) were attributed to other risk factors such as transfusions or prenatal exposure. *Id.* at 7.

45 The CDC estimates that, in 2010, African American youth represented 57% (n=7,000) of infections. See *HIV Among Youth*, *supra* note 1. Hispanic and Caucasian youth each represented approximately twenty percent of new infections among youth (20%, n=2,390; 20%, n=2,380). *Id.*

46 Rod McCullom, *Lowering the Age for HIV Prevention*, ATLANTIC, Feb. 11, 2015, <http://theatlntc/1MnuHZy> [<http://perma.cc/7EMA-PK4T>].

47 See *supra* notes 41–44 and accompanying text.

48 See *Substance Abuse/Use*, AIDS.GOV, <https://www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/substance-abuse-use> [<https://perma.cc/6UAW-CC74>] (last updated Jan. 14, 2014).

49 According to 2013 estimates by the U.S. Department of Health and Human Services (HHS), 28% of participants in state-funded needle exchange programs in Massachusetts reported being under age twenty at first injection. *Massachusetts HIV/AIDS Data Fact Sheet: Injection Drug Users*, MASS. DEP'T OF PUB. HEALTH (Jan. 1, 2014), <http://www.mass.gov/eohhs/docs/dph/aids/2014-profiles/idu.pdf> [<http://perma.cc/5LT5-96Y2>].

50 See S. Chatterjee et al., *Changes in the Prevalence of Injection Drug Use Among Adolescents and Young*

the risk of infection. As such, IDU-youth require specially tailored HIV prevention modalities that help protect against both syringe-sharing and sexual risks.

Injection drug use among youth crosses the socio-economic spectrum, but is a significant program among youth experiencing homelessness. In fact, homeless or unstably housed youth are more likely to engage in a number of HIV risk behaviors, such as intercourse without condoms, sharing syringes, sex in exchange for value, sex with an intravenous drug user, and sex with a person living with HIV.⁵¹ Developing new, comprehensive HIV prevention programs for homeless or unstably housed youth is especially important; in the United States, homeless or unstably housed youth⁵² are two to ten times more likely to contract HIV than adolescents who have stable housing.⁵³

Another neglected population of youth especially prone to HIV infection is detained youth. Detained youth often have multiple sexual partners.⁵⁴ For example, in one study analyzing HIV risk behaviors and STI history of 1,215 detained youth, 75% of the cohort studied reported having three or more sexual partners, and 20% reported no condom use.⁵⁵ Detained youth engaging in injection drug use are especially vulnerable to HIV infection if sterile injection equipment is unavailable. Detained youth engaging in sexual and/or IDU-related risk require comprehensive HIV prevention methods tailored to the harsh realities of confinement.

Adults in Large U.S. Metropolitan Areas, 15 AIDS BEHAV. 1570, 1570–71 (2011), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3299409/> [<http://perma.cc/4734-9MMW>]; *HIV and Injection Drug Use in the United States*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/hiv/riskbehaviors/idu.html> [<http://perma.cc/6QF5-TVQQ>] (last updated Oct. 27, 2015).

51 *HIV/AIDS Among Persons Experiencing Homelessness: Risk Factors, Predictors of Testing, and Promising Testing Strategies*, IN FOCUS, Dec. 2012, at 1, http://www.nhchc.org/wp-content/uploads/2011/09/InFocus_Dec2012.pdf [<http://perma.cc/K944-8VHJ>].

52 When I refer to “homeless youth” in this Article, I am referring to a broad spectrum of young people, including runaway, unstably housed, castaway, unaccompanied, systems, and street youth.

53 *See id.*

54 *See* Matthew C. Aalsma et al., *Mental Health Screening and STI Among Detained Youth*, 36 J. CMTY. HEALTH 300 (2010).

55 R.J. Canterbury et al., *Prevalence of HIV-Related Risk Behaviors and STDs Among Incarcerated Adolescents*, 17 J. ADOLESCENT HEALTH 173, 174–75 (1995), <http://www.ncbi.nlm.nih.gov/pubmed/8519785> [<http://perma.cc/YJM5-D2TG>]. For additional statistics, see Linda A. Teplin, *Major Mental Disorders, Substance Use Disorders, Comorbidity, and HIV-AIDS Risk Behaviors in Juvenile Detainees*, 56 PSYCHIATRIC SERVS. 823 (2005).

While YMSM, IDU-youth, homeless youth, and detained youth are populations of young people who face a significant risk of HIV infection, it is also important to highlight another sub-population of youth who are also at significant risk of infection but have been largely overlooked: the HIV-negative partner in a heterosexual, serodiscordant youth couple. HIV-negative youth in serodiscordant (sometimes termed “serodifferent”) relationships—that is, relationships in which one partner is living with HIV and the other is not—will likely be a growing risk group in the future as a result of HIV normalization and advances in HIV treatment. New prevention approaches will be needed when such couples consider pregnancy, particularly in cases where an HIV-negative adolescent female is seeking pregnancy with a male living with HIV. At least one study in adults established an association between heterosexual women living with HIV whose infection was behaviorally acquired, and the desire for pregnancy.⁵⁶ Finger and associates’ study “suggested that [the desire for pregnancy] was associated with increased likelihood of . . . condom-unprotected sex.”⁵⁷ In developing HIV prevention programs targeting at-risk youth, serodiscordant youth couples cannot be overlooked.

In the populations I have identified above, the potential health-related harms to these youths, and to public health more generally, make examining our current HIV prevention models for any gaps, and developing new and effective HIV prevention modalities to fill those gaps, a necessity. To that end, in Part C, I review our predominant approach to HIV prevention among youth, and in Part D, I introduce PrEP—a comprehensive prevention strategy that protects at-risk youths against HIV regardless of the method of exposure or the choices they may make.

C. Traditional HIV Prevention Methods for Youth

The predominant approach to HIV prevention among youth is education. Youths receive information on sex and sexual health from a variety of sources, including friends, family, school, non-profit organizations, and the media. Of these, the two most enduring day-to-day sources for most youths are schools and parents, guardians, and other adult caregivers. In this section, I argue that access to complete and accurate information about HIV—or any information about HIV at all—from these two sources is particularly problematic. First, I argue that because sexual education programs vary across the country, information about HIV prevention is inconsistent. Moreover, even in “comprehensive sex education” states

56 Julie J. Finger et al., *Desire for Pregnancy and Risk Behavior in Young HIV-Positive Women*, 26 AIDS PATIENTS CARE & STDs 173, 174 (2012).

57 *Id.* at 173.

that permit or require instruction about proper and consistent condom use, studies have shown that youth are loath to use condoms. Second, HIV remains stigmatized, which could cause at-risk youth who may already feel marginalized to forgo parental advice about sex entirely. Thus, although these two informational strategies have proved effective in some respects, they must be supplemented with a pharmacological prevention safety net to curb the rise in HIV incidence among at-risk youth.

1. Access to Information about HIV Prevention

One of the enduring sexual risk prevention modalities for youth is educational programming in schools.⁵⁸ This approach to educating youth on sex and sexual health, however, varies on a jurisdictional basis, and the efficacy of each model of sexual education is highly contested. The types of sexual education programming found in schools today are variations on one of two themes: comprehensive and abstinence-only education.⁵⁹ The comprehensive approach includes discussion of abstinence, but also includes STI prevention instruction about condom usage.⁶⁰ One meta-analysis of eighty-three studies that measured the effectiveness of comprehensive programming on HIV-related risk behavior found this approach can have a positive impact on “delay[ing] or decreas[ing] sexual behaviors or increas[ing] condom or contraceptive use.”⁶¹ On the other hand, traditional abstinence-only education focuses on abstinence as the sole “morally correct” way to avoid contracting an

58 See generally GUTTMACHER INST., IN BRIEF: FACT SHEET – FACTS ON AMERICAN TEENS’ SOURCES OF INFORMATION ABOUT SEX (Feb. 2012), <http://www.guttmacher.org/pubs/FB-Teen-Sex-Ed.html> [<http://perma.cc/LS9S-GUL7>] (summarizing the various sources of information about sex for youth in the United States).

59 See NICOLE VITELLONE, OBJECT MATTERS: CONDOMS, ADOLESCENCE AND TIME 5 (2008). For a discussion of the history of sex education programs, see *id.* at 13–35. For a complete side-by-side comparison of programs, see *Sex Education Programs: Definitions and Point-by-Point Comparison*, ADVOCATES FOR YOUTH (2001), <http://www.advocatesforyouth.org/publications/publications-a-z/655-sex-education-programs-definitions-and-point-by-point-comparison> [<http://perma.cc/5PKG-YJAN>]. See also KAISER FAMILY FOUNDATION, SEX EDUCATION IN AMERICA 45 (2000), <https://kaiserfamilyfoundation.files.wordpress.com/2000/09/3048-sex-education-in-america-a-view-from-inside-the-nations-classrooms.pdf> [<http://perma.cc/3RG9-Y7DS>] (last visited June 24, 2015) (comparing student perceptions after having enrolled in abstinence-only or comprehensive sex-ed programs).

60 *Siecus Fact Sheet*, SEXUALITY INFO. & EDUC. COUNCIL OF THE UNITED STATES (Oct. 2009), <http://www.siecus.org/index.cfm?fuseaction=Page.ViewPage&PageID=1193> [<http://perma.cc/R8Y7-QSBS>].

61 See D. Kirby, *Sex and HIV Programs: Their Impact on Sexual Behaviors of Young People Throughout the World*, 40 J. ADOLESCENT HEALTH 206, 206–17 (2007) (referring to comprehensive programs as “curriculum-based”). See also *Comprehensive Sex Education: Research and Results*, ADVOCATES FOR YOUTH (Sept. 2009), <http://www.advocatesforyouth.org/publications/1487> [<http://perma.cc/V34D-FBXX>] [hereinafter *Research and Results*].

STI or unwanted pregnancy, and may offer incomplete information about HIV prevention or eliminate information about HIV entirely.⁶² No traditional abstinence-only program that takes a moralistic approach has proven effective in decreasing STI infections among youth.⁶³

However, at the behest of state law- and policy-makers, school-based sex and HIV education is decidedly moralistic. A 2015 Guttmacher survey of state sex and HIV education regulations, statutes, and “other legally binding policies” found that a majority of U.S. states mandate that, when schools include sex and HIV education, information about abstinence must be included.⁶⁴ The survey also found that half of all United States states require that educators “stress” abstinence,⁶⁵ and that only a minority of states require that curricula is “medically accurate.”⁶⁶ Further, the survey found that only two states forbid the promotion of religion, and eight states require unbiased instruction.⁶⁷ Nonetheless, emphasis on abstinence without giving adolescents complete and accurate information about reducing

62 See 3 SCIENCE AND SUCCESS: SEX EDUCATION AND OTHER PROGRAMS THAT WORK TO PREVENT TEEN PREGNANCY, HIV, AND SEXUALLY TRANSMITTED INFECTIONS, ADVOCATES FOR YOUTH (2012), <http://www.advocatesforyouth.org/storage/advfy/documents/thirdeditionexecutivesummary.pdf> [<http://perma.cc/GF4G-XLUP>] (last visited July 3, 2015).

63 See *Research and Results*, *supra* note 61, at 2. There is some evidence that theory-based abstinence-only programs—that is, programs that, unlike traditional abstinence-only programs, do not take a moralistic approach to prevention—can be effective at delaying sexual involvement and reducing HIV-related behavioral risks. See John B. Jemmott et al., *Efficacy of a Theory-Based Abstinence-Only Intervention Over 24 Months: A Randomized Controlled Trial with Young Adolescents*, 164 ARCHIVES PEDIATRICS & ADOLESCENT MED. 152, 157 (2010), <http://nationalabstinenceclearinghouse.com/pdf/contentmgmt/abstinence.pdf> [<http://perma.cc/S48L-QWDW>]; *Research and Results*, *supra* note 61, at 10.

64 GUTTMACHER INST., STATE POLICIES IN BRIEF: SEX AND HIV EDUCATION 2–3 (Dec. 1, 2015), http://www.guttmacher.org/statecenter/spibs/spib_SE.pdf [<http://perma.cc/T5KX-YM7P>] [hereinafter GUTTMACHER STATE POLICIES IN BRIEF]. Only nineteen states require that sexuality education be “medically, factually, or technically” accurate, though definitions of “medically accurate” are subject to variation. *But see State Policies on Sex Education in Schools*, NAT’L CONF. ON STATE LEGISLATORS, <http://www.ncsl.org/research/health/state-policies-on-sex-education-in-schools.aspx> [<http://perma.cc/TC4T-K2JN>] (last updated Feb. 13, 2015) [hereinafter *State Policies on Sex Education*].

65 See GUTTMACHER STATE POLICIES IN BRIEF, *supra* note 64, at 2.

66 See *id.* at 1 (finding that thirteen states require that curricula be “medically accurate”). See also *State Policies on Sex Education*, *supra* note 64 (placing the number of states that require sexuality education to be “medically, factually or technically” accurate at nineteen and noting that definitions of “medically accurate” are subject to variation).

67 GUTTMACHER STATE POLICIES IN BRIEF, *supra* note 64, at 3.

harm when risk behavior inevitably occurs⁶⁸ will not likely be effective at reducing the negative consequences of risky sexual behavior. This is especially true since the number of students receiving HIV education in public schools has actually decreased in recent years,⁶⁹ and data on effectiveness of education provided by community organizations is lacking.⁷⁰

Apart from education in the public sphere, adult figures such as parents and guardians are also an important source of information. A parental role in sexual education before the youth's first instance of sexual intercourse has been shown to increase condom use.⁷¹ In one study, youth who talked with their mothers before their first sexual encounter were three times more likely to use a condom when first having sex than those who never had a discussion with a parent.⁷² However, the fact remains that many American youth feel unable to discuss sexual healthcare with their parents or guardians,⁷³ and for youth whose behavior might be considered morally suspect, discussion of sexuality has the potential to result in physical and emotional abuse.⁷⁴ These threats become a barrier to receipt of information about sexual health.

To illustrate, LGBTQ youth face “sexual orientation-specific stressors [of] ‘coming

68 KM Leslie, Can. Pediatric Ass'n, *Harm Reduction: An Approach to Reducing Risky Health Behaviours in Adolescents*, 13 PEDIATRICS & CHILD HEALTH 53, 54 (2008) (reaffirmed Feb. 1, 2014).

69 Of all fifty U.S. states, thirty-three require HIV education, see *State Policies on Sex Education*, *supra* note 64, but the percentage of students who receive education on HIV has decreased from ninety-two percent in 1997 to eighty-five percent in 2013. *HIV Among Youth*, *supra* note 1.

70 For a list of community organizations that promote and offer comprehensive sex education, see *Organizations Working on Comprehensive Sex Education*, ADVOCATES FOR YOUTH, <http://www.advocatesforyouth.org/sercadv/1376?task=view> [<http://perma.cc/SA2W-K4F5>] (listing religiously affiliated organizations). See also CENTER: THE LESBIAN, GAY, BISEXUAL & TRANSGENDER COMMUNITY CENTER, <https://gaycenter.org/wellness/hiv-aids#hiv-and-aids-prevention-education> [<http://perma.cc/R5R7-SR25>] (last visited July 3, 2015).

71 *Patterns of Condom Use Among Adolescents*, CTRS. FOR DISEASE CONTROL & PREVENTION (Oct. 1, 1998), <http://1.usa.gov/1J04lpc> [<http://perma.cc/5J77-6PVG>] [hereinafter *Patterns of Condom Use*].

72 *Id.*

73 See Press Release, Planned Parenthood, Half of Teens Feel Uncomfortable Talking With Parents (Oct. 2, 2012), <http://www.plannedparenthood.org/about-us/newsroom/press-releases/half-all-teens-feel-uncomfortable-talking-their-parents-about-sex-while-only-19-percent-parents> [<http://perma.cc/MH62-YSTZ>].

74 See, e.g., Alex Morris, *The Forsaken: A Rising Number of Homeless Gay Teens Are Being Cast Out by Religious Families*, ROLLING STONE, Sept. 3, 2014, <http://rol.st/1Bc3a1O> [<http://perma.cc/X97E-YJLG>]; Curtis M. Wong, *Jacqueline Alexander, Tennessee Mother, Allegedly Beat Son Because She Thought He Was “Too Feminine” and Gay*, HUFFINGTON POST, Feb. 20, 2015, <http://huff.to/1M5EjHx> [<http://perma.cc/2ZS7-CTWG>].

out' to parents,⁷⁵ victimization in school,⁷⁶ and abuse at home. Because discussion of HIV prevention between YMSM and parents can result in outing, embarrassment, violence, and disownment, this makes receiving information concerning HIV at home particularly difficult. But to make matters worse, Dr. Brian C. Thoma and associates noted in 2014 that “[n]o effective intervention strategies have been developed to reduce HIV risk behaviors in samples of . . . [Y]MSM with a mean age of less than [twenty-three].”⁷⁷ In short, YMSM are at a significant informational disadvantage with regard to HIV prevention compared to their heterosexual counterparts. Not only may YMSM have difficulty receiving information about HIV from schools and parents, but they may also have difficulty receiving information from their government and from community organizations. These informational disadvantages are paradigmatic of those facing other at-risk youth populations such as IDU-youth and incarcerated youth, who by virtue of their marginalization may not have the same ability as low-risk youth to prevent HIV. In this regard, developing effective HIV prevention strategies for these at-risk youth is a public health *and* social justice imperative.

Nonetheless, even if at-risk youth have access to information about HIV prevention, we must examine how that information is perceived, and balance our aspirations for youth behavior with their realities. As I discuss in the next section, condom messaging, one of the pillars of comprehensive sex and HIV education for youth, is problematic because condom usage remains deeply unpopular among youth. This poses another barrier to effective HIV prevention among at-risk youth.

2. Content of Information About HIV Prevention

“I HATE using condoms. I hate it. They almost dismiss the intimacy of sex and make it more of a business exchange[,] [n]ot to mention feeling not even half as good . . .”⁷⁸

75 Thoma & Huebner, *supra* note 40, at 1605 (noting that “[p]arent-child dynamics change in important ways when a child is gay or bisexual: family rejection is common, communication can be strained, and secrecy looms in families where a child has not yet ‘come out’”).

76 See generally David M. Huebner et al., Abstract, *School Victimization and Substance Use Among Lesbian, Gay, Bisexual, and Transgender Adolescents*, 16 PREVENTION SCI. 734, 734 (2015), <http://link.springer.com/article/10.1007/s11121-014-0507-x> [<http://perma.cc/5FEX-632T>] (“Preventive interventions for LGBT adolescents must not only attempt to make schools safer for these youth, but also help keep them engaged in healthy peer groups when they are confronted with mistreatment in school.”).

77 Thoma & Huebner, *supra* note 40, at 1604.

78 Brian Mustanski et al., *A Mixed-Methods Study of Condom Use and Decision Making Among Adolescent*

Condom education is considered “a critical and primary intervention strategy”⁷⁹ to curb youth STI infection and pregnancy, but it is clear that the strategy has failed to curb HIV incidence in those youth most at risk of HIV infection. I have argued in a prior article that, as evidenced by the troubling, continued rise in HIV infection among certain high-risk groups despite nearly thirty years of condom messaging, condoms have failed as the primary HIV prevention modality in the United States among the adult population.⁸⁰ Research also shows that the efficacy of condom messaging among at-risk youth is on the decline. Indeed, condom use among youth under eighteen years of age has declined since 2003.⁸¹ In 1991, condom use among high school students was at 46%.⁸² Condom usage peaked in 2003 at 63%.⁸³ However, as of 2013, condom usage was down to 59%.⁸⁴ In the 2013 National Youth Risk Behavior Survey by the CDC, of the 13,633 youth surveyed in grades nine through twelve,⁸⁵ 41% of sexually active youth—34% of the youth population surveyed—did not use a condom the last time they had intercourse.⁸⁶ In a 2013 study of African American YMSM, 67% of the cohort studied reported that they had unprotected receptive anal intercourse in the previous six months.⁸⁷

Gay and Bisexual Males, 18 AIDS & BEHAV. 1955, 1961 (2014) (quoting the perspective of an adolescent study participant).

79 *Id.* at 1955–56.

80 Burda, *supra* note 3, at 172, 179–81.

81 CTRS. FOR DISEASE CONTROL & PREVENTION, SEXUAL RISK BEHAVIORS AMONG U.S. HIGH SCHOOL STUDENTS (July 2014), <http://www.cdc.gov/nchstp/newsroom/docs/factsheets/yrbs-fact-sheet-final-508.pdf> [<http://perma.cc/PSH3-X8JM>].

82 CHILD TRENDS DATA BANK, CONDOM USE: INDICATORS ON CHILDREN AND YOUTH (July 2014), at 2, http://www.childtrends.org/wp-content/uploads/2012/07/28_Condom_Use.pdf [<http://perma.cc/N92H-NPW5>].

83 *Id.*

84 Press Release, U.S. Ctrs. for Disease Control & Prevention, CDC Releases 2013 Youth Risk Behavior (YRBS) Results (June 12, 2014), <http://www.cdc.gov/Features/YRBS> [<http://perma.cc/S99L-S2WY>].

85 Ctrs. for Disease Control & Prevention, *Youth Risk Behavior Surveillance – United States, 2013*, MORBIDITY & MORTALITY WKLY. REP., June 13, 2014, at 1, <http://1.usa.gov/1sNLbC8> [<http://perma.cc/2REX-255Y>].

86 *HIV and Other STD Prevention and United States Students*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/healthyouth/yrbs/pdf/us_hiv_combo.pdf [<http://perma.cc/EU4J-N69N>] (last visited July 3, 2015).

87 Richard A. Crosby et al., *Acceptability of Condoms, Circumcision and PrEP Among Young Black Men Who Have Sex with Men: A Descriptive Study Based on Effectiveness and Cost*, 2 VACCINES 129, 131 (2014), <http://www.mdpi.com/2076-393X/2/1/129/htm> [<http://perma.cc/98KG-TVFF>]; see also Burda, *supra* note 3,

One potential explanation for this decline in condom usage is youth attitudes towards condoms. In a 2014 study of seventy-five fourteen to eighteen year-old gay and bisexual males,⁸⁸ Mustanski and associates found that, regarding youth attitudes about condom usage, there were two recurring themes. First, among the cohort studied, the most common reasons for not using condoms were that the availability of HIV and STI testing “can enable you to know when a sex partner is ‘clean’” and when condom-less sex is appropriate.⁸⁹ Second, as expressed by one study participant, “many don’t like it because it doesn’t feel as good as without a condom.”⁹⁰ Regarding perceived pleasure decreases, even though approximately 61% of youth participants reported that condoms are “smart” to use or should be used, over 50% reported that the decrease in pleasure resulting from using condoms was the reason to not use them.⁹¹ This suggests that youth perceptions that condoms are unnecessary (if partners are frequently tested) and anesthetizing may help explain low usage rates.

Yet I propose a third reason that may cause negative youth attitudes about condoms: messages to youth about the importance of practicing condom vigilance and their protective benefit lack credibility. In fact, I have noted in a previous article that “condoms are medically effective at preventing HIV, eliminating approximately 90–95% of the transmission risk when used properly and vigilantly.”⁹² However, data concerning condom effectiveness in *practice* indicate that the actual efficacy of condoms is likely around 60–70% due to nonuse, intermittent use, and improper use.⁹³ In the words of Dr. Janet Woodcock, Director of the Center for Drug Evaluation and Research at the U.S. Food and Drug Administration, the actual efficacy of condoms is likely “much lower, because many individuals do not use them correctly or use them at all.”⁹⁴ By extension, when one considers biological,

at 180.

88 Mustanski et al., *supra* note 78, at 1959–60.

89 *Id.* at 1961.

90 *Id.*

91 *Id.* at 1959.

92 Burda, *supra* note 3, at 179 (citing Steven D. Pinkerton & Paul R. Abramson, *Effectiveness of Condoms in Preventing HIV Transmission*, 44 SOC. SCI. & MED. 1303, 1310 (1997)).

93 *Id.* at 179–80; Pinkerton & Abramson, *supra* note 92, at 1304 (citing Susan C. Weller, *A Meta-Analysis of Condom Effectiveness in Reducing Sexually Transmitted HIV*, 36 SOC. SCI. & MED. 1635, 1640 (1993)). See also U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, HIV SURVEILLANCE REPORT: HIV RISK, PREVENTION, AND TESTING BEHAVIORS 8 (2011) (concluding that, “despite prevention efforts, a large proportion of MSM have sex without using condoms and do not know their partner’s HIV status before having sex”).

94 See Letter from Janet Woodcock, Dir., Ctr. for Drug Evaluation & Res., to Tom Myers, Gen. Couns.,

behavioral, and social influences on youth risk behavior, the rate of proper and consistent condom usage among youth may be even lower than among adults. It is certainly possible that youth are beginning to question the credibility of condom messaging since the rate of intermittent, improper, and nonuse of condoms among youth (and the adults on whom youth model their behavior) is so high.

What this reveals is that, to curb HIV infections among youth, advocates and policy-makers must begin to rethink both HIV prevention content delivery, and the content itself. Indeed, harm reduction strategies would probably be more productive at reducing HIV incidence among youth than sex and HIV educational programs designed to teach risk avoidance and behavioral modification.⁹⁵

D. Pharmacological HIV Prevention and PrEP

Like oral contraception, which is a means to insure against the unintended consequences of sexual intercourse, pharmacological HIV prevention is a means to insure youth against the lifelong consequences of HIV-related risk.⁹⁶

Pharmacological HIV prevention entails the prescription of pharmacologies by a physician or advanced practice nurse for the purpose of preventing infection. Examples of pharmacological HIV preventions include, but are not limited to: (a) oral, topical, injectable, or implantable pre-exposure prophylaxis (“PrEP”) to prevent transmission in the event of future exposure; (b) oral *post*-exposure prophylaxis (“PEP” or “nPEP”) taken by HIV-negative individuals for a finite period after an actual exposure to HIV infection; (c) “treatment as prevention” or “TasP,” which entails treatment of HIV-positive individuals

AIDS Healthcare Found., at 11 (July 16, 2012), <http://1.usa.gov/1Ls2SPJ> [<http://perma.cc/4L6X-8T4P>] [hereinafter Letter from Janet Woodcock] (citing Pinkerton & Abramson, *supra* note 92, at 1306–07); Burda, *supra* note 3, at 187.

95 See Steinberg, *What Changes, and Why?*, *supra* note 32, at 57. In his article, Dr. Steinberg notes that:

Rather than attempting to change the way adolescents evaluate risky activities (which is, in essence, what health education programs attempt to do), a more profitable strategy might focus on limiting opportunities for immature judgment to have harmful consequences Strategies such as . . . expanding access to . . . contraceptive services . . . would likely be more effective . . . than strategies aimed at making adolescents wiser, less impulsive, or less short-sighted.

Id.

96 *Id.*

with ARVs as a means of suppressing the HIV virus and preventing infection of others; and (d) HIV vaccines.⁹⁷ Of these, none has exploded onto the clinical research scene with the same force that PrEP has.

The efficacy of PrEP in adults has been clearly established in numerous clinical trials, observational studies, and post-trial analyses.⁹⁸ Oral PrEP administered as a daily dose of Truvada is effective at preventing HIV in adults, with an efficacy of above ninety percent for those who take it consistently, and possibly higher.⁹⁹ The CDC has stated that: “PrEP is a powerful HIV prevention tool and can be combined with condoms and other prevention methods to provide even greater protection than when used [without condoms].”¹⁰⁰

In 2012, the FDA approved the combination of emtricitabine/tenofovir disoproxil fumarate (TDF/FTC) marketed as Truvada under an exclusive patent by Gilead Sciences, for daily dosage in pill form by at-risk, HIV-negative adults.¹⁰¹ The clinical profile of Truvada for PrEP applications includes those individuals with partners living with HIV, as well as those having sex in high prevalence social groups or who have partners of unknown HIV status. In both of the latter cases, individuals should have at least one of the following risk factors: (a) intermittent or no condom usage; (b) STI infection; (c) exchange of value for sex; (d) illicit drug use; and/or (e) incarceration.¹⁰² In 2013, the United States Public Health

97 See Burda, *supra* note 3, at 182; Underhill, *supra* note 3, at 610.

98 Burda, *supra* note 3, at 182–87.

99 See *id.* at 184. See also CTRS. FOR DISEASE CONTROL & PREVENTION, PREEXPOSURE PROPHYLAXIS FOR THE PREVENTION OF HIV INFECTION IN THE UNITED STATES—2014: A CLINICAL PRACTICE GUIDELINE 12–13 (2014), <http://www.cdc.gov/hiv/pdf/PrEPguidelines2014.pdf> [<http://perma.cc/2LV8-EJHC>] [hereinafter CDC GUIDELINES]; *PrEP: How Well Does PrEP Work?*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/hiv/basics/prep.html> [<http://perma.cc/K62V-EDR9>] (last updated June 25, 2015). Recent studies have shown that PrEP is up to ninety-nine percent effective when used daily. See, e.g., Peter L. Anderson et al., *Emtricitabine-Tenofovir Concentrations and Pre-Exposure Prophylaxis Efficacy in Men Who Have Sex with Men*, 4 SCI. TRANSLATIONAL MED. 151ra125-1 (2012); *What is the iPrEx Study?*, iPREX OLE, <http://www.iprexole.com/lpages/prep/prep-whatistheiprexstudy.php> [<http://perma.cc/P8WB-LJSW>] (noting that the iPrEx Ole study found that Truvada as PrEP provides “99% protection against HIV infection in MSM”).

100 *Pre-exposure Prophylaxis (PrEP)*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/hiv/prevention/research/prep> [<http://perma.cc/LDG7-F66P>].

101 For an extensive discussion of the road to FDA approval of Truvada as PrEP, see Burda, *supra* note 3, at 186–89.

102 Gilead Sciences, Inc., *Truvada: Package Insert and Label Information*, DRUGINSERTS.COM, <https://druginserts.com/lib/rx/meds/truvada-5> [<https://perma.cc/PJ94-SHGC>] (last revised Dec. 23, 2013). See also Burda, *supra* note 3, at 188–89.

Service (USPHS) issued clinical practice guidelines for adults, calling use of Truvada as PrEP “safe and effective.”¹⁰³ Indeed, there is a critical mass of research indicating that the long-term side effects of PrEP in adults are minimal, though additional longitudinal research is ongoing.¹⁰⁴

However, PrEP is not merely a medication; it is a multi-dimensional, comprehensive prevention strategy for at-risk individuals involving periodic testing, monitoring, and supervision.¹⁰⁵ The FDA has indicated that, prior to receiving a prescription for Truvada as PrEP, the provider should conduct screenings for HIV and other sexually transmitted infections, tests for hepatitis B, and an analysis of kidney functioning.¹⁰⁶ During treatment, the patient should receive quarterly HIV tests, periodic tests for kidney functioning as needed, and counseling on safer-sex practices.¹⁰⁷ Accordingly, PrEP is a prophylactic therapy that requires continued engagement with healthcare providers.

Delivering this comprehensive prevention strategy to at-risk adults has proved challenging despite a deluge of media attention.¹⁰⁸ Uptake has been slow, though adult pre-

103 CDC GUIDELINES, *supra* note 99. See also Burda, *supra* note 3, at 189–90 (discussing the CDC’s final guidance and its implications for wider implementation of PrEP).

104 See Letter from Janet Woodcock, *supra* note 94 (detailing the FDA’s assessment of the long term medical and behavioral risks). Subsequent to FDA approval, at least one double-blind, placebo-controlled study has confirmed that the risk of kidney impairment is minimal. See also Kenneth K. Mugwanya et al., *Changes in Glomerular Kidney Function Among HIV-1-Uninfected Men and Women Receiving Emtricitabine-Tenofovir Disoproxil Fumerate Preexposure Prophylaxis: A Randomized Clinical Trial*, 175 JAMA INTERNAL MED. 246, 252–53 (2015). Another recent study showed a mild loss in bone density in adults. Kathleen Mulligan et al., *Effects of Emtricitabine/Tenofovir on Bone Mineral Density in HIV-Negative Persons in a Randomized, Double-Blind, Placebo-Controlled Trial: DXA Results from iPrEx*, 61 CLINICAL INFECTIOUS DISEASES 572 (2015), <http://www.ncbi.nlm.nih.gov/pubmed/25908682> [<http://perma.cc/KL4N-3YDL>] (last visited July 10, 2015). See Michael Carter, *Truvada PrEP Causes Only Mild Loss of Bone Mineral Density*, AIDS MAP, May 14, 2015, <http://www.aidsmap.com/iTruvadai-PrEP-causes-only-mild-loss-of-bone-mineral-density/page/2967903> [<http://perma.cc/3RSY-22CC>]. Loss in bone density could be of greater concern in the context of PrEP for youth, though research here is lacking.

105 See U.S. FOOD & DRUG ADMIN., REMS FOR TRUVADA FOR A PRE-EXPOSURE PROPHYLAXIS (PREP) INDICATION 3 (2014), <http://1.usa.gov/1ChkFG7> [<http://perma.cc/CKJ6-DK9G>] [hereinafter GILEAD REMS].

106 See PROJECT INFORM, IS TAKING PREP THE RIGHT CHOICE FOR YOU? 9 (2014), http://www.projectinform.org/pdf/prep_msm.pdf [<http://perma.cc/WX7F-YEYJ>].

107 See GILEAD REMS, *supra* note 105, at 3, 6. See also SAN FRANCISCO AIDS FOUND., PREP FACTS 7–8 (2014), http://prepfacts.org/assets/PrEP_Facts_16-pager_brochure_mech_FINAL.pdf [<http://perma.cc/H85T-S6ZV>] (containing plain-English information about the recommended PrEP regimen).

108 See Burda, *supra* note 3, at 174–75, 190–92. See also Shari Rudavsky, *Drug Protects Against HIV But*

scriptions have begun to increase more rapidly as a result of coordinated efforts at the state and local levels¹⁰⁹ and through the support of national non-profit organizations.¹¹⁰ If implementation of PrEP among adults has proved challenging, operationalizing PrEP for youth will likely be even more difficult.

One reason for this is that the FDA has yet to approve Truvada as PrEP for use by at-risk youth, and no federal or state public health agency has issued guidance with respect to PrEP for minors. According to the U.S. Public Health Service, “the data on the efficacy and safety of PrEP for adolescents are insufficient.”¹¹¹ There is some evidence that Truvada as PrEP is safe and medically effective for young adults ages eighteen through twenty-four,¹¹² but there are no completed studies pertaining to youth under eighteen years of age.¹¹³

Not Many Take It, INDIANAPOLIS STAR, July 6, 2015, <http://www.indystar.com/story/news/2015/07/06/drug-protects-hiv-many-take/29670455> [<http://perma.cc/73JC-RFLV>]; Abby Sewell, *L.A. County Planning to Distribute Controversial HIV Prevention Drug*, L.A. TIMES, June 9, 2015, <http://www.latimes.com/local/lanow/la-me-ln-county-hiv-truvada-20150609-story.html> [<http://perma.cc/S87N-QEG7>]; Jennifer Wright, *Awareness of Pill to Prevent HIV Is Growing*, PHILA. DAILY NEWS, June 26, 2015, http://articles.philly.com/2015-06-26/news/63865437_1_truvada-medication-gilead-sciences-inc [<http://perma.cc/6K5N-A342>].

109 See, e.g., *PrEP Prescriptions on Dramatic Upswing in New York State*, AIDS MEDS, May 14, 2015, http://www.aidsmeds.com/articles/New_York_PrEP_1667_27238.shtml [<http://perma.cc/8VGU-LQBX>] (noting recent estimation of 4,000 PrEP prescriptions in San Francisco and a rise in prescriptions in New York).

110 E.g., Statement, AIDS United, AIDS United Statement on Pre-Exposure Prophylaxis (PrEP) (Nov. 24, 2014), http://www.aidsunited.org/data/files/Site_18/AIDS%20United%20Statement%20on%20PrEP%20-%20FINAL.pdf [<http://perma.cc/JJ2F-4ASY>] (noting that “AIDS United signed on to the June 17, 2014 community statement by more than 160 organizations in support of the CDC guidelines [for Truvada as PrEP] and maintains its support of this statement”).

111 See CDC GUIDELINES, *supra* note 99 (recommending PrEP “to reduce the risk of acquiring HIV infection in adults”). Research is still lacking for adolescents under age eighteen, in part because of the medical, ethical, and legal concerns with testing adolescent subjects. See R.J. Levine, *Research Involving Adolescents as Subject: Ethical Considerations*, 1135 ANN. N.Y. ACAD. SCI. 280 (2008), <http://www.ncbi.nlm.nih.gov/pubmed/18574234> [<http://perma.cc/7LJC-XZYG>]; *Society for Adolescent Medicine, Guidelines for Adolescent Health Research*, 33 J. ADOLESCENT HEALTH 396 (2003), https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Nov-03-Guidelines_for_Adolescent_Health_Research.pdf [<http://perma.cc/M34U-JSR5>].

112 See, e.g., Sybil Hosek et al., *Project PrEPare (ATN082): The Acceptability and Feasibility of an HIV Pre-Exposure Prophylaxis (PrEP) Trial with Young Men who Have Sex with Men (YMSM)*, 62 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 447 (2013), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3656981> [<http://perma.cc/GFZ7-35P2>].

113 A number of clinical concerns will likely need to be addressed prior to FDA approval. First, there is concern about ensuring pre- and post-prescription testing, and adherence to the PrEP regimen, as well as confirming minimal behavioral disinhibition and long-term side effects. See CDC GUIDELINES, *supra* note 99,

Indeed, for the FDA to approve of Truvada as PrEP, studies will need to include adolescent subjects.¹¹⁴

Nonetheless, the U.S. Public Health Service has provided clinical considerations to physicians about PrEP for youth.¹¹⁵ Furthermore, it is common practice to treat minors with

at 42. One point that has not been explored is the added importance of the testing regimen for youth. Many youth who acquire HIV through sexual risk-taking were unaware of their HIV status. Ctrs. for Disease Control & Prevention, *Vital Signs: HIV Infection, Testing, and Risk Behaviors Among Youths—United States*, 61 MORBIDITY & MORTALITY WEEKLY REP. 971 (2012), <http://1.usa.gov/1SEp5cm> [<http://perma.cc/M33B-VT8M>] (finding, in 2009, that “[m]ore than half (59.5%)” of youths ages thirteen through twenty-four living with HIV “were unaware of their infection, the highest for any age group”). As such, it is possible that at-risk youth may seek PrEP prevention even though they are already infected. Because use of Truvada as PrEP by those unknowingly infected face a risk (albeit relatively low) of ARV resistance, this issue is worthy of exploration in the context of youth. See Emily Newman, *PrEP and Drug Resistance: Cause for Concern?*, BETA BLOG (Apr. 6, 2015), <http://betablog.org/prep-and-drug-resistance-cause-for-concern> [<http://perma.cc/8ZKM-32PX>]. Adherence is also a significant concern. Studies have found that “HIV-infected adolescents are especially vulnerable to specific adherence problems on the basis of their psychosocial and cognitive developmental trajectory,” and for HIV-negative youth who are not dependent upon ARVs to avoid onset of AIDS, issues of adherence may be more pronounced. NAT’L INST. OF HEALTH, GUIDELINES FOR THE USE OF ANTIRETROVIRAL AGENTS IN HIV-1-INFECTED ADULTS AND ADOLESCENTS 1-9 (2015) (emphasis added), <https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf> [<http://perma.cc/6STZ-DEGS>] (last visited July 5, 2015). More studies are needed to confirm that potential long-term side effects associated with Truvada as PrEP (such as mild loss in bone density and renal impairment) do not have a more pronounced effect on youth whose bodies are not yet mature. *But see* Vania Giacomet et al., *A 12-month Treatment With Tenofovir Does Not Impair Bone Mineral Accrual in HIV-Infected Children*, 40 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 448 (2005) (concluding that “a TDF-containing antiretroviral regimen does not seem to impair bone mineral accrual in children showing a good immunologic response to antiretroviral treatment”). Finally, there is growing concern that prescription of PrEP to at-risk youth could lead to an increase in condomless intercourse and solidify the propriety of risk-taking behavior during a period of increased neural plasticity and development of sexual identity.

114 Moore et al., *supra* note 6, at 40–42 (noting that parental consent is necessary for a minor subject to participate in PrEP studies).

115 See CDC GUIDELINES, *supra* note 99, at 9, 42–43. The U.S. Public Health Service states the following about the appropriateness of PrEP for adolescent minors:

Although the FDA labeling information specifies PrEP indications for “adults,” an age above which an adolescent is considered an adult is not provided. None of the completed PrEP trials have included persons under the age of 18. Therefore, clinicians should consider carefully the lack of data on safety and effectiveness of PrEP taken by persons under 18 years of age, the possibility of bone or other toxicities among youth who are still growing, and the safety evidence available when TDF/FTC is used in treatment regimens for HIV-infected youth. These factors should be weighed against the potential benefit of providing PrEP for an individual adolescent at substantial risk of HIV acquisition.

ARVs once diagnosed with HIV. Based upon some data confirming the safety and efficacy of ARVs for youth under eighteen living with HIV, the CDC and the HHS has included adolescents among its adult recommendations for early identification of HIV and early treatment with ARVs.¹¹⁶ As such, a federal endorsement of ARVs as a prophylactic therapy for HIV-negative youth less than eighteen years of age is realistic.

Federal endorsement of PrEP for youth is a threshold issue to operationalizing PrEP for youth. An additional threshold issue is cost. In the United States, youth are disproportionately impacted by poverty,¹¹⁷ and the percentage of youth living in poverty and low income has increased over time.¹¹⁸ LGBTQ youth, including YMSM particularly at risk of HIV infection, are “disproportionately represented among homeless youth” in the United States.¹¹⁹ As such, concerns about the cost of healthcare to the patient are amplified in the youth population. To be sure, PrEP is an expensive prophylactic therapy. One 2013 study using Medicare allowables estimated that the aggregate of costs in connection with the PrEP regimen, including the wholesale price of Truvada (an average of \$1,425 per month), laboratory work, and counseling, is approximately \$18,000 per patient per year in the United States.¹²⁰ Although insurers are currently covering Truvada as PrEP,

Id. at 43.

116 Ctrs. For Disease Control & Prevention, *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*, 55 MORBIDITY & MORTALITY WEEKLY REP. 1, Sept. 22, 2006, <http://www.cdc.gov/mmwr/preview/mmwrhtml/tr5514a1.htm> [<http://perma.cc/8GR4-VB5E>]; U.S. DEP’T OF HEALTH & HUM. SERVS., *Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents*, <https://aidsinfo.nih.gov/contentfiles/lvguidelines/AdultAndAdolescentGL.pdf> [<http://perma.cc/E6PW-4BAH>] (last updated Apr. 8, 2015).

117 While children comprise twenty-four percent of the United States population, they represent thirty-four percent of all people living in poverty. SOPHIA ADDY ET AL., NAT’L CTR FOR CHILDREN IN POVERTY, *BASIC FACTS ABOUT LOW-INCOME CHILDREN: CHILDREN UNDER 18 YEARS*, 2011 1 (2013) http://www.nccp.org/publications/pdf/text_1074.pdf [<http://perma.cc/9XGW-KT6R>].

118 *See id.* at 2.

119 ANDREW CRAY ET AL., CTR. FOR AM. PROGRESS, *SEEKING SHELTER: THE EXPERIENCES AND UNMET NEEDS OF LGBT HOMELESS YOUTH* 7 (2013), <https://www.americanprogress.org/issues/lgbt/report/2013/09/26/75746/seeking-shelter-the-experiences-and-unmet-needs-of-lgbt-homeless-youth> [<https://perma.cc/ZU24-9KSA>].

120 Burda, *supra* note 3, at 200 (citing Michael Horberg & Brian Raymond, *Financial Policy Issues for HIV Pre-Exposure Prophylaxis: Cost and Access to Insurance*, 44 AM. J. PREVENTIVE MED. S125, S125 (2013), [http://www.ajpmonline.org/article/S0749-3797\(12\)00696-4/pdf](http://www.ajpmonline.org/article/S0749-3797(12)00696-4/pdf) [<http://perma.cc/4D2U-TST4>]). It appears that, since 2013, the average wholesale price of Truvada has increased. *See* PANEL ON ANTIRETROVIRAL GUIDELINES FOR ADOLESCENTS & ADULTS, U.S. DEP’T OF HEALTH & HUMAN SERVS., *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents K-20*, <http://aidsinfo.nih.gov/contentfiles/lvguidelines/adultand>

PrEP may be unaffordable to many adults due to maximum out-of-pocket deductibles, coinsurance, and co-pays.¹²¹ In the context of youth access to PrEP, these costs would likely be prohibitive, especially because most insured youth are dependent on a parent or caregiver's ability—and willingness—to pay. Making PrEP accessible to at-risk youth will require the development of solutions that render PrEP entirely cost-free.¹²²

The threshold issues of clinical safety/efficacy of PrEP for youth and the cost of PrEP will require careful analysis by experts in these fields. Yet there is a primacy to addressing these concerns; there is little chance of operationalizing PrEP for youth on a wide scale without FDA approval and securing cost-free delivery. Nonetheless, while the FDA has not approved Truvada as PrEP for use by individuals under eighteen years of age, physicians have the ability to prescribe Truvada as PrEP to this group.¹²³ In fact, some providers may have already begun doing so. In light of the off-label availability of Truvada as PrEP to

adolescentgl.pdf [<https://perma.cc/3BGN-ZX3F>] (last updated Apr. 8, 2015) (listing average wholesale price of Truvada as \$1,539.90).

121 Burda, *supra* note 3, at 201.

122 Private and public co-pay assistance programs that cover a portion of the cost depending upon income, such as the Gilead Co-Pay Assistance Program for Truvada and Washington State's Pre-Exposure Prophylaxis Drug Assistance Program, have made PrEP more affordable to many adults. Eligibility for Washington's program is not age-dependent, while those eligible for Gilead's program must be age eighteen or older. See WASH. DEP'T OF HEALTH, PRE-EXPOSURE PROPHYLAXIS DRUG ASSISTANCE PROGRAM (PrEP DAP) CONFIDENTIAL APPLICATION, at 3, <http://www.doh.wa.gov/Portals/1/Documents/Pubs/150-053-PrEPDAPApplication.pdf> [<http://perma.cc/MEQ3-7QPW>] (last visited July 6, 2015) (listing eligibility requirements); *Truvada for PrEP Medication Assistance Program*, GILEAD, <http://www.gilead.com/responsibility/us-patient-access/truvada%20for%20prep%20medication%20assistance%20program> [<http://perma.cc/6ZJW-9TKT>] (last visited July 10, 2015) (stating that the program "assists eligible HIV-negative adults"). In the future, co-pay programs should not condition eligibility upon age. Those eligible for assistance should include youth insured as dependents, youth insured as dependents but who decline to provide details of insurance coverage due to privacy concerns, and uninsured youth.

Public health advocates and policymakers have also begun pushing for municipal PrEP subsidy programs. In San Francisco, for example, City Supervisor David Campos recently proposed a measure to allocate funds to subsidize the out-of-pocket costs associated with PrEP for those who cannot afford the prophylaxis. See Lydia O'Connor, *San Francisco May Be the First City to Give Out Free HIV-Prevention Pills*, HUFFINGTON POST, Sept. 19, 2015, http://www.huffingtonpost.com/2014/09/19/san-francisco-free-hiv-prevention-pills-prep-truvada_n_5847454.html [<http://perma.cc/2HXJ-XM6J>].

123 Tanya L. Kowalczyk Mullins et al., Abstract, *Clinician Attitudes Toward CDC Interim Pre-exposure Prophylaxis (PrEP) Guidance and Operationalizing PrEP for Adolescents*, 29 AIDS PATIENT CARE STDs 193 (2015), <http://www.ncbi.nlm.nih.gov/pubmed/25692683> [<http://perma.cc/4NE8-PC5X>] (“[O]ral PrEP may be used off-label for youth.”).

youth, it is important to begin addressing the major accessibility and acceptability hurdles that may prohibit uptake.

In Part II, I argue that the major accessibility hurdle to PrEP for youth is parental involvement in youth healthcare decisions. Pursuant to the laws of every U.S. jurisdiction, breaches of confidentiality resulting from parental consent and notification are not just permissible under state law, they're compelled. Such breaches, or the threat of such breaches, form a major barrier to youth access to sexual healthcare therapies such as PrEP. In Part III, I argue that that major acceptability hurdle to PrEP for youth will likely be stigma resulting from incomplete HIV prevention education.

II. Ensuring PrEP Accessibility Without Parental Involvement

Most youth lack independence from parental figures.¹²⁴ In the healthcare context, the general rule is that minors—youth under the age of majority pursuant to state law, most often under eighteen years of age—are incapable of making informed decisions about health and welfare that require understanding and weighing risks and benefits. State laws shift that responsibility to the parental figure.¹²⁵ For example, with limited exceptions, surgeons may not perform non-emergency surgery on minors without obtaining parental consent.¹²⁶ This is true even if the minor has the mental faculties to decide for him or herself whether the benefits outweigh the risks. Thus, the general rule is that minors lack confidential healthcare as a result of the involvement of third-party decision-makers. Ensuring that minors have access to confidential sexual healthcare is a vexing problem, and there is much scholarship devoted to the issue.¹²⁷ One author put the dilemma this way: “[W]hat health care services

124 See Kimberly M. Mutcherson, *Whose Body Is It Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents*, CORNELL J.L. & PUB. POL'Y 251, 257 (2005) (noting that “[w]hile adolescent minors have more legal authority than they used to have, for the most part they still must follow the direction of their parents”).

125 See Richard C. Boldt, *Symposium: Adolescent Decision Making: Legal Issues With Respect to Treatment for Substance Misuse and Mental Illness*, 15 J. HEALTH CARE L. & POL'Y 101, 105 (2012); Alicia Ouellette, *Body Modification and Adolescent Decision Making*, 15 J. HEALTH CARE L. & POL'Y 101, 105 (noting that “the law vests parents with decision-making authority of teenagers”); Jennifer L. Rosato, *Let's Get Real: Quilting a Principled Approach to Adolescent Empowerment in Health Care Decision-Making*, 51 DEPAUL L. REV. 769, 769 (2002) (“In the health care context, . . . even older adolescents are presumed incompetent to make basic health care decisions.”).

126 See generally Ouellette, *supra* note 123, at 106–07 (discussing parental consent in the context of cosmetic surgery).

127 E.g., Diane M. Reddy et al., *Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual*

[would] competent adults . . . forego if their employers, spouses, or family members were notified of their medical procedures and consultations[?]"¹²⁸

Indeed, there is often a conflict between the interests of minors and their parents in the context of HIV-related health decisions that works as a disincentive to prompt treatment of the minor. This can have devastating consequences on the health of the minor. The California Supreme Court stated it aptly:

[P]articularly in matters concerning sexual conduct, minors frequently are reluctant, either because of embarrassment or fear, to inform their parents of medical conditions relating to such conduct, and consequently . . . there is a considerable risk that minors will postpone or avoid seeking needed medical care if they are required to obtain parental consent before receiving medical care for such conditions.¹²⁹

This observation is well established in social science literature. In seeking sexual healthcare, approximately half of all adolescents would prefer to eschew services than permit their providers to notify a parent of their decisions to take birth control.¹³⁰ Another eleven percent of adolescents would delay STI testing and treatment if the provider were required to notify a parent.¹³¹

In an effort to protect the health of minors in situations where they would sooner forgo treatment than secure the consent of a parent or guardian, lawmakers have passed laws acting as exceptions to the general rule that minors may not make their own healthcare decisions. These exceptions, such as those permitting minors to consent to STI treatment, permit sensitive healthcare decisions without adult consent and, in some instances, further secure the confidentiality of minors in such situations by permitting providers to forgo

Health Care Services, 288 JAMA 710 (2002), <http://jama.jamanetwork.com/article.aspx?articleid=195185> [<http://perma.cc/CA2M-92BW>] (concluding that “[m]andatory parental notification for prescribed contraceptives would impede girls’ use of sexual health care services, potentially increasing teen pregnancies and the spread of STDs”); Arshagouni, *supra* note 12, at 323.

128 Arshagouni, *supra* note 12, at 323.

129 *Am. Acad. of Pediatrics v. Lungren*, 940 P.2d 797, 802 (Cal. 1997).

130 N. LABOR ET AL., *HEALTHY TEENS INITIATIVE*, *supra* note 11.

131 *Id.*

parental notification.¹³² In HIV prevention advocacy, there is increasing interest in how these exceptions may facilitate confidential access to PrEP therapy for minors.¹³³

In the next section, I divide my analysis into two broad categories of laws affecting confidential access to healthcare for minors: (a) state consent laws; and (b) parental notification laws. In both, I consider the implications for operationalizing PrEP for minors and make specific suggestions for advocates, policymakers, and lawmakers.

A. State Consent Laws

Minor access to confidential healthcare, particularly sexual healthcare, is complicated by a lack of uniformity among the states as to what medical services may be provided without parental consent, and there is a great deal of provider confusion and concern about liability. The liability concerns of providers are compound. For a provider to avoid liability for battery, the patient must effectively consent to treatment.¹³⁴ To avoid professional negligence, such consent must be informed and properly disclosed.¹³⁵ Additionally, a provider who furnishes care to marginalized youth may now need to be concerned about a potential criminal charge of contributing to the delinquency or neglect of a minor for facilitating conduct considered morally reprehensible.¹³⁶ These liability fears are motivating providers to investigate the variability in adolescent health and wellness-related laws across United States jurisdictions.¹³⁷ In the context of PrEP, a therapy not without political controversy, provider concerns about whether minors may consent are amplified, and may result in the delay of necessary HIV prevention or blanket bans on PrEP for youth altogether.

132 *See id.*

133 *See generally* Culp & Caucci, *supra* note 6, at 119 (suggesting that “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”).

134 Mykitiuk et al., *supra* note 19, at 994.

135 *Id.*

136 In a much-watched Virginia case, an adult transgender activist was charged with contributing to the delinquency of a minor, a class-1 misdemeanor, for assisting a seventeen-year-old suicidal trans teenager in finding counseling and housing because the teenager’s father disapproved. *See* Brad Kutner, *Lynchburg Transadvocate Arrested After Assisting At-Risk Youth*, GAYRVA.COM (Apr. 9, 2015), <http://www.gayrva.com/news-views/lynchburg-transadvocate-arrested-after-assisting-at-risk-youth> [<http://perma.cc/62WZ-84KZ>].

137 E-mail from Jason Potter Burda to Daniel Bruner (May 19, 2015, 10:06 EST) (on file with author); e-mail from Daniel Bruner to Jason Potter Burda (May 19, 2015, 11:37 EST) (on file with author); e-mail from Daniel Bruner to Jason Potter Burda (May 19, 2015, 18:24 EST) (on file with author).

The purpose of this section is to provide a framework for understanding the patchwork of state consent laws pertaining to minor consent to medical treatment, with the specific goal of pinpointing statutory inroads to operationalizing PrEP for youth without parental consent. I divide these state consent laws into three kinds: (1) laws permitting minors to self-consent in specific healthcare-related situations, focusing here on STI prevention and treatment; (2) laws permitting certain minors to consent to general medical care based on particular personal, social, or family circumstances; and (3) state emergency medical treatment laws that, rather than grant decision-making authority to minors, merely *imply* parental consent. Of these three types of laws, I argue that laws permitting minors to consent in connection with STI prevention and treatment, which exist in all United States jurisdictions in various forms, offer the most realistic state-level opportunity for operationalizing PrEP on a confidential basis. As such, I conducted a comprehensive survey of these STI consent laws in all fifty United States jurisdictions and the District of Columbia, the results of which I summarize next.

1. Minor Consent Pursuant to STI Consent Statutes

All United States jurisdictions and the District of Columbia permit providers to rely on a minor's consent in the context of sexually transmitted diseases.¹³⁸ These statutes are a legislative recognition that, "while parental involvement in minors' health care decisions is desirable, many minors will not avail themselves of important services if they are forced to

138 Culp & Caucci, *supra* note 6, at 121; Moore et al., *supra* note 6, at 41. Only South Carolina lacks a dedicated statute permitting minors to consent to STI services. However, South Carolina's broad consent statute permits minors to receive any care a physician deems necessary without parental consent. *Id.* at 121. By implication, minors may self-consent to STI services in South Carolina.

States also permit minors to consent to care in the pregnancy and family planning context, as well as in the addiction treatment context. Some family planning exceptions may enable HIV-negative female minors considering pregnancy with an HIV-positive male partner to consent to PrEP. *See, e.g.*, DEL. CODE ANN. tit. 13, § 710(a) (2015) ("A minor 12 years of age or over who professes to be either pregnant . . . or who professes to be exposed to the chance of becoming pregnant, may give written consent . . . to any licensed physician, hospital or public clinic for any diagnostic, *preventive*, lawful therapeutic procedures, medical or surgical care and treatment . . .") (emphasis added); VA. CODE ANN. § 54.1-2969(E)2 (2015) (permitting minor consent for "[m]edical or health services required in case of birth control, pregnancy or family planning"). Some addiction exceptions may allow IDU-using minors, to consent to PrEP. *See, e.g.*, N.H. REV. STAT. ANN. § 318-B:12-a (2015) (permitting "[a]ny minor 12 years of age or older [to] voluntarily submit himself to treatment for drug dependency . . . or any problem related to the use of drugs . . . without the consent of a parent, guardian, or any other [adult caregiver]") (emphasis added); TENN. CODE ANN. § 63-6-220(a) (2015) ("Physicians may treat juvenile drug abusers without prior parental consent."). However, further discussion of these ideas is beyond the scope of this Article.

involve their parents.”¹³⁹ As such, they are an excellent starting point for operationalizing PrEP.¹⁴⁰

Comprehensive research conducted for this Article¹⁴¹ among the fifty United States and the District of Columbia indicates that statutes permitting minors to consent to services in connection with sexually transmitted diseases¹⁴² may be divided into three types: (1) those that are narrowly tailored, permitting minor self-consent to care attendant to actual or suspected STIs; (2) those that are more broadly tailored, permitting minor self-consent to STI services in the event the of actual or perceived exposure to an STI; and (3) those that are tailored the broadest, permitting minors to consent to preventive STI care. This framework provides a useful means of synthesizing the numerous variations among these statutes and developing advocacy recommendations with respect to each type.

a. Narrowly-Tailored Statutes: Diagnosis and Treatment of STIs

Nearly half of all United States jurisdictions have narrowly tailored STI consent statutes.¹⁴³ These statutes typically limit minor consent to testing, treatment, and prescription

139 See GUTTMACHER INST., STATE POLICIES IN BRIEF, AN OVERVIEW OF MINORS’ CONSENT LAW (2015), http://www.gutmacher.org/statecenter/spibs/spib_OMCL.pdf [<http://perma.cc/Y6T8-ZA6F>]. See also CDC GUIDELINES, *supra* note 99, at 42 (“Parental/guardian involvement in an adolescent’s health care is often desirable but is sometimes contraindicated for the safety of the adolescent.”).

140 Two peer-reviewed studies have addressed the issue of minor access to PrEP pursuant to STI consent statutes. See Culp & Caucci, *supra* note 6, at 119; Moore et al., *supra* note 6, at 40. Culp and Caucci surveyed minor STI consent statutes and implications for operationalizing PrEP for self-consenting minors pursuant to such statutes. Culp & Caucci, *supra* note 6, at 120. This study was limited to minor STI consent statutes and did not consider other statutory exceptions to the general rule that minors may not consent to their own healthcare. See *id.* at 119. In the second study, Moore and associates argued that the patchwork of minor STI consent statutes across U.S. jurisdictions is a barrier to conducting research regarding PrEP and other STI pharmacologies on adolescent subjects. See Moore et al., *supra* note 6, at 40.

141 The research conducted in connection with STI exceptions was executed independently of, and the results confirmed by, Culp and Caucci’s study. Moore and associates’ 2016 article incorporated Culp and Caucci’s findings. See Moore et al., *supra* note 6, at 44.

142 The definition of STI varies among the states. Some statutes refer to STIs as “sexually transmitted disease,” “venereal disease,” or “reportable disease.” Some minor STI consent statutes specifically mention HIV. See, e.g., MICH. COMP. LAWS § 333.5127(1) (2015) (includes specific mention of HIV); OR. REV. STAT. § 109.610 (2016) (includes specific mention of HIV); 23 R.I. GEN. LAWS § 23-6.3-3(*l*) (2016) (includes specific mention of HIV).

143 See *infra* Appendix, Tbl.1.

in connection with actual STI infections.¹⁴⁴ Some statutes specify a minimum age, and some are silent as to age.¹⁴⁵ With regard to the type of care permitted, many states explicitly permit the minor to consent to the diagnosis and treatment of STIs,¹⁴⁶ yet do not explicitly permit minors to consent to preventive care.¹⁴⁷ Because PrEP is not diagnostic in nature, in these jurisdictions (which comprise almost half of all U.S. states), minors would likely be required to obtain parental consent for PrEP therapy unless it may be characterized as a “treatment” under these statutes.¹⁴⁸ However, the statutes themselves rarely provide insight as to whether treatment includes care that is preventive in nature. To be sure, with few exceptions,¹⁴⁹ STI consent statutes typically do not define the term “treatment” at all.

144 See *id.* Some statutes that purport to limit the care to diagnosis and treatment of STIs are, in fact, more vague and deserve further investigation. For example, Kentucky’s minor STI consent statute states that “[a]ny physician . . . with the consent of [the] minor may advise, prescribe for, and treat such minor regarding venereal disease.” KY. REV. STAT. ANN. § 214.185 (West 2015) (emphasis added). It is unclear whether “prescribe for . . . venereal disease” requires the minor to have a confirmed diagnosis for that disease. In this statute, because the legislature specifically broke out treatment as a separate consent item, there is an argument that a minor does not need to be actually diagnosed with an STI to receive a prescription in connection with preventing that STI. Additionally, in the Kentucky statute, it is unclear what “treat such minor regarding” an STI means. PrEP is a treatment regarding HIV. This may open the door to PrEP without parental consent. Missouri’s minor STI consent statute is equally as vague, permitting minors to consent “in case of . . . [v]enereal disease.” MO. REV. STAT. § 431.061(4) (2015) (emphasis added). PrEP is prescribed *in case of* HIV infection. This, too, may open the door to PrEP without parental consent.

145 Compare N.H. REV. STAT. ANN. § 141-C:18 (2015) (minimum age of fourteen) with KY. REV. STAT. ANN. § 214.185 (no minimum age specified).

146 See, e.g., N.H. REV. STAT. § 141-C:18; *infra* Appendix, Tbl.1.

147 Moore and associates proffer that there exists “little evidence” that consent statutes permitting minor self-consent to STI treatment were “consciously crafted” by legislatures to omit preventive care. Moore, *supra* note 6, at 42.

148 Culp & Caucci, *supra* note 6, at 122 (“[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.”).

149 E.g., TEX. HEALTH & SAFETY CODE ANN. § 313.002(6) (West 2015) (defining “treatment” in the context of consent to medical care generally as “a health care treatment, service, or procedure designed to maintain or treat a patient’s physical or mental condition, as well as preventative care”) (emphasis added). Moore and associates maintain that there exists “little evidence” that consent statutes permitting minor self-consent to STI treatment were “consciously crafted [by legislatures] to exclude prevention.” Moore et al., *supra* note 6, at 42.

Nonetheless, some statutes pertaining to minor consent to general medical care,¹⁵⁰ as well as statutes pertaining to HIV confidentiality and testing,¹⁵¹ do define “treatment” to include prevention, and there is little to suggest that the definition of treatment in connection with minor STI consent should be any different. Other health- and safety-related laws provide further support for this interpretation. For example, jurisdictions define “treatment” as including preventive care in the context of nursing,¹⁵² sports medicine,¹⁵³ disability,¹⁵⁴ mental health,¹⁵⁵ and healthcare regulation.¹⁵⁶ Additionally, federal occupational safety regulations applicable to all U.S. jurisdictions consider the prescription of all medications, including prophylaxes, as treatments.¹⁵⁷ Case law, too, may provide further support.¹⁵⁸ These primary authorities (in areas of health, wellness, and safety) all support the idea that prevention—and, by extension, PrEP—is a type of treatment and might be furnished

150 *E.g.*, DEL. CODE ANN. tit. 13, § 707(a)(2) (2015) (defining “medical treatment” including “ordinary and necessary medical and dental examination and treatment, including blood testing, preventive care including ordinary immunizations, tuberculin testing and well-child care”); FLA. STAT. § 743.0645(1)(b) (2015) (defining “medical care and treatment” as “includ[ing] ordinary and necessary medical . . . treatment, including blood testing, preventive care including ordinary immunizations, tuberculin testing, and well-child care”); OR. REV. STAT. § 109.572(4) (2015) (defining “medical treatment” as including “ordinary and necessary medical, dental and optical examination and treatment and preventive care including ordinary immunizations, tuberculin testing and well-child care . . .”).

151 ILL. ADMIN. CODE. tit. 77 § 693.10 (2015) (defining “treatment” as including “services for prevention, diagnosis, and medical management of STIs”).

152 *E.g.*, FLA. STAT. § 464.003(18) (2015) (defining “nursing treatment” as including care for “the prevention of illness”).

153 *E.g.*, D.C. CODE § 3-1201.02(2A-ii)(D)(iii) (2015) (defining “treatment” as including “the prevention, evaluation . . . management, treatment . . . or reconditioning of an athletic injury”).

154 *E.g.*, ARK. CODE ANN. § 20-48-1102(5A)(B) (2015) (defining “early intervention day treatment” as including “preventive . . . therapies”).

155 N.M. STAT. ANN. § 24-7B-3(G) (2015) (defining “mental health treatment” as including services “provided for the prevention of . . . mental illness”).

156 MINN. R. 9505.1696 (2015) (defining “treatment” as “the prevention, correction, or amelioration of a disease . . .”).

157 *See* Letter from Keith Goddard, U.S. Dep’t of Labor, to Dave Beyer (Mar. 10, 2005), https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_id=25233 [https://perma.cc/M6X8-FTX5].

158 *See generally* Parents United for Better Sch., Inc. v. Sch. Dist. of Phila. Bd. of Educ., 978 F. Supp. 197, 207 (E.D. Pa. 1997), *aff’d*, 148 F.3d 260 (3d Cir. 1998) (finding condom distribution a health service rather than treatment in part because condoms are “non-invasive” and “do not require medical training or supervision for their use,” but placing weight on the prophylactic, non-diagnostic nature of condoms).

without parental consent in treatment-specific jurisdictions. Finally, from the clinical perspective, it is appropriate to regard PrEP as analogous to a treatment because PrEP is a comprehensive regimen involving far more than HIV testing and diagnosis. Because PrEP involves a prescription, periodic testing, counseling, and monitoring, as well as supervision by a physician or advanced practice nurse in perpetuity, it more closely resembles actual HIV treatment than traditional prevention services.

If the definition of “treatment” includes preventive care, providers in narrowly tailored STI consent jurisdictions—almost half of the United States—may be able to rely on an at-risk minor’s consent to PrEP therapy. Therefore, in jurisdictions with narrowly tailored STI consent statutes, it will be important for advocates to work with legislatures and policymakers to clarify that the term “treatment” includes preventive care. In the alternative, advocates may work with legislatures to amend narrowly tailored statutes to permit self-consent to diagnosis, treatment, *and* preventive care.¹⁵⁹

b. Broader Statutes: Care Related to, or Prescription for, STIs

A number of jurisdictions have broader minor STI consent statutes, specifying that minors may consent not only to the diagnosis and treatment of STIs, but also to “care” related to an STI in the event of an actual or suspected exposure.¹⁶⁰ In Indiana, for example, a physician may rely on the consent of a minor who has, or suspects he or she has, an STI to furnish “medical or hospital care or treatment.”¹⁶¹ In jurisdictions specifying that a provider may furnish “care” to self-consenting minors, whether PrEP is included may depend upon the definition of “care.” Some statutes specify this definition. In Indiana, for example, “health care” means “any care, treatment, service, or procedure to maintain, diagnose, or treat an individual’s physical or mental condition.”¹⁶² Because PrEP therapy is prescribed to maintain an individual’s current HIV-negative status, it is likely that PrEP would meet Indiana’s statutory definition of “care.” Advocates in jurisdictions permitting physicians to rely on minor self-consent in the provision of “care” related to actual or suspected STI exposure should consult statutory definitions of care and seek legislative clarification if needed. Advocates may also need to seek clarification as to whether their jurisdiction’s

159 See *infra* Appendix, Tbl.3.

160 See *infra* Appendix, Tbl.2.

161 IND. CODE § 16-36-1-3(d) (2015) (emphasis added); see *infra* Appendix, Tbl.2.

162 IND. CODE § 16-36-1-1(2015).

statute would permit minor consent even if a minor's professed suspicions are ultimately unsubstantiated.

Other jurisdictions permit physicians to “prescribe for” actual or suspected exposure to an STI. In New York, for example, a physician may “prescribe for” a minor who has actually been infected with an STI “or has been exposed to infection” without obtaining parental consent.¹⁶³ In these jurisdictions, there is little to suggest that a minor who believes he or she has been exposed to HIV through risky behavior could not self-consent to a pharmacological prophylaxis. In fact, legislatures in a minority of jurisdictions have made this explicit, permitting minor consent to prophylactic treatment in the event of suspected exposure to HIV.¹⁶⁴

While statutes permitting minors to consent to “care” for, or to receive prescriptions in the event of, actual or suspected exposure to STIs are an improvement over narrow statutes only permitting self-consent to the diagnosis and treatment of STIs, there are still a number of uncertainties in these statutes that may lead to provider confusion and delay as related to PrEP. Therefore, advocates should work in concert with legislatures to amend these statutes and explicitly permit minor self consent to the prevention of STIs.

c. Broadest Statutes: Adding Preventive Care

Seven United States jurisdictions explicitly permit minors to consent to preventive

163 N.Y. PUB. HEALTH LAW § 2305(2) (McKinney 2015) (emphasis added). It is unclear whether the New York statute requires *actual* exposure (say, in the occupational context of a documented pin prick with HIV-infected blood) or whether suspected or feared exposure to STI (say, in the more common scenario a YMSM whose concern over recent condomless intercourse with a partner of unknown HIV status) would be sufficient.

164 See KAN. STAT. ANN. § 65-2892 (2015); NEB. REV. STAT. § 71-504 (2015); S.D. CODIFIED LAWS § 34-23-16 (2015); *infra* Appendix, Tbl.2. In South Dakota, for example, minors may consent to the “prescri[ption] for and treat[ment] . . . for [STIs], including prophylactic treatment for exposure to [STIs] whenever such person is suspected of having a venereal disease or contact with anyone having a venereal disease.” S.D. CODIFIED LAWS § 34-23-16 (emphasis added); see also KAN. STAT. ANN. § 65-2892 (2015) (“Any physician, upon consultation by any person under eighteen (18) years of age as a patient, may, with the consent of such person who is hereby granted the right of giving such consent, make a diagnostic examination for venereal disease and prescribe for and treat such person for venereal disease including prophylactic treatment for exposure to venereal disease whenever such person is suspected of having a venereal disease or contact with anyone having a venereal disease.”); NEB. REV. STAT. § 71-504 (2015) (“[M]ake or cause to be made a diagnostic examination for sexually transmitted diseases and prescribe for and treat such person for sexually transmitted diseases including prophylactic treatment for exposure to sexually transmitted diseases whenever such person is suspected of having a sexually transmitted disease or contact with anyone having a sexually transmitted disease.”).

STI care,¹⁶⁵ which by implication would permit providers to rely on the consent of minors to PrEP and other pharmacological HIV prevention therapies. In Oklahoma, for example, minors are permitted to consent to preventive STI care in the event of prior infection with an STI.¹⁶⁶ California imposes an age restriction of age twelve or older,¹⁶⁷ while other jurisdictions permit self-consent to preventive STI care at any age.¹⁶⁸ Pursuant to the broadest minor STI consent law in the nation, the District of Columbia permits minors of any age to consent to “any services which he or she requests for the prevention, diagnosis, or treatment of . . . [a] sexually transmitted disease.”¹⁶⁹ Delaware specifically permits a minor twelve years old or over the ability to self-consent to preventive care if the minor believes she is infected.¹⁷⁰

Thus, in those seven jurisdictions permitting minors to self-consent to preventive STI care, the language of these statutes implies that minors may self consent to PrEP, which is prescribed to prevent HIV. However, most statutes do not typically define the terms “prevention” or “preventive care.” These terms are commonly understood as including preventions such HIV screening and counseling, but it is certainly not clear whether these terms may be fairly interpreted, consistent with legislative intent, to include

165 See *infra* Appendix, Tbl.3. See also Moore et al., *supra* note 6, at 41.

166 OKLA. STAT. tit. 63, §§ 2601, 2602 (2015). In Oklahoma, if a minor is or has been infected with a reportable communicable disease, the minor may consent to prevention, diagnosis, and treatment of reportable diseases. The statute does not specify that prevention must relate to the same STI with which the minor was previously infected. *Id.* Under the Oklahoma statute, it may be possible for a minor previously infected with syphilis, for example, to self-consent to prescription of PrEP to prevent HIV infection.

167 CAL. FAM. CODE § 6926(a) (West 2015) (“A minor who is 12 years of age or older may consent to medical care related to the prevention of a sexually transmitted disease.”).

168 D.C. MUN. REGS. tit. 22, § 600.7, 7(c) (2015) (“A minor of any age may consent to health services which he or she requests for the prevention, diagnosis, or treatment of . . . [a] sexually transmitted disease.”); IOWA CODE § 139A.35 (2015) (“A minor shall have the legal capacity to act and give consent to provision of medical care or services to the minor for the prevention, diagnosis, or treatment of a sexually transmitted disease or infection by a hospital, clinic, or health care provider.”); N.C. GEN. STAT. § 90-21.5(a) (2015) (“Any minor may give effective consent . . . for medical health services for the prevention, diagnosis and treatment of . . . venereal disease” and other reportable diseases).

169 D.C. MUN. REGS. tit. 22, § 600.7.

170 DEL. CODE ANN., tit. 13, § 710(a) (2015) (“A minor 12 years of age or over who professes to be . . . afflicted with contagious, infectious or communicable diseases . . . may give written consent . . . for any diagnostic, preventive, lawful therapeutic procedures, medical or surgical care and treatment.”). See also MONT. CODE ANN. § 41-1-402(2)(c) (2015) (“[A] minor who professes or is found to be . . . afflicted with any [STI]” may consent to the “prevention, diagnosis, and treatment of those conditions specified in this subsection.”).

pharmacological prophylaxes, which carry potential long-term side effects and require close medical supervision. Clarification will be needed.

Notwithstanding this concern, advocates should begin to focus on jurisdictions that explicitly include preventive care as the starting point in operationalizing PrEP for self-consenting minors pursuant to STI consent statutes. Providers in these states should investigate developing policies, in collaboration with legal counsel, that permit minors to consent to PrEP, closely tailoring those policies to the specific requirements in their respective minor STI consent statute. One jurisdiction that is well-positioned to make advances on PrEP for at-risk youth without third party consent is the District of Columbia, which as of 2013, had almost three times the number of new HIV infections among adolescents age thirteen through nineteen years per 100,000 population (43.1%, n=832) than Louisiana, the state with the next highest rate of infection (15.4%, n=297).¹⁷¹

However, state-level solutions such as this are only one piece of the puzzle. Federal solutions are also needed to address, among other issues, the choice of law complications that may lead to provider confusion and the delay of necessary care. While choice of law is more assured with patients who receive care at the provider's home base, choice of law is more nebulous when providers interact with extra-jurisdictional patients outside the brick-and-mortar clinical environment. Providers and administrators often communicate with extra-jurisdictional patients via phone, through electronic patient portals, or using other virtual means. Must a clinic that operates in the District of Columbia but also draws its patient base from a number of other jurisdictions (such as Maryland, Virginia, Delaware, West Virginia, and Pennsylvania)¹⁷² consider the STI consent laws of other jurisdictions when its physicians or staff interact with the patient within his or her home jurisdiction in connection with care furnished pursuant to an STI consent law? If so, which STI consent law applies? While such D.C.-based clinic could furnish PrEP to at-risk youth without parental consent pursuant to the District of Columbia's broad minor STI consent statute (which includes STI prevention),¹⁷³ the ability of this provider to do the same is more tenuous when interacting telephonically or electronically with patients living in Maryland

171 See *CDC Surveillance Slideshow*, *supra* note 44, at 9.

172 E-mail from Daniel Bruner to Jason Potter Burda (Oct. 2, 2015, 16:18 EST) (on file with author). See also WHITMAN-WALKER HEALTH ANNUAL REPORT 3 (2013), http://ymlvr1c1g6r30e7oixxve462.wpengengine.netdna-cdn.com/wp-content/uploads/2014/11/WHH-2013-Annual-Report_FINAL.pdf [<http://perma.cc/MVK4-2S78>] (noting that nearly 70% of patients came from the District of Columbia, 16% of patients from Maryland, and 11% from Virginia in 2013).

173 See *CDC Surveillance Slideshow*, *supra* note 44.

and Virginia, where the minor STI consent statutes are narrower and pertain only to diagnosis and treatment of STIs.¹⁷⁴ If communications occur, can the provider continue to rely on the minor's original consent made in the District of Columbia? This choice of law complication is paradigmatic of the challenges that arise as a result of significant variations in STI consent laws across United States jurisdictions. Such challenges have the potential to engender provider confusion and delay in providing services to at-risk minors, which in turn may lead to altogether preventable HIV infections. This is one justification for developing federal solutions that would help streamline confidential access to PrEP for minors.

2. Minor Consent Pursuant to Emancipation Exceptions

A minor who has reached the age of majority is automatically considered emancipated, but those *under* the age of majority who achieve legal emancipation, either by statutory mandate or judicial decree, have a greatly expanded range of rights and responsibilities.¹⁷⁵ All states have laws pertaining to the emancipation of minors who have not yet reached the age of majority. Emancipation may be *de jure* or *de facto*. *De jure* emancipation, or emancipation by law, occurs through court intervention, where a minor petitions a court to grant him or her the rights and responsibilities of adulthood. *De jure* emancipation, while an important tool, is of minimal significance for operationalizing PrEP for at-risk minors. Concerns about cost, privacy, and delay inherent in court intervention would likely be prohibitive for the majority of at-risk youth. Thus, operationalizing PrEP for minors without parental consent will require reviewing more economically feasible, confidential, and efficient solutions.

De facto emancipation, or emancipation by right, is enabled by state statute and occurs when a minor has achieved a certain status or has certain "individual or social circumstances."¹⁷⁶ In these limited circumstances, the law presumes that the minor has the capacity to understand the risks and benefits of adult activities, and the minor may consent

174 MD. CODE ANN., HEALTH-GEN. § 20-102(c)(3) (West 2015) ("A minor has the same capacity as an adult to consent to . . . treatment for or advice about venereal disease."); VA. CODE ANN. § 54.1-2969(E)1 (2015) (consent of minor is valid for "[m]edical or health services needed to determine the presence of or to treat venereal disease").

175 See Arshagouni, *supra* note 12, at 334.

176 Rhonda Gay Hartman, *Coming of Age: Devising Legislation for Adolescent Medical Decision-Making*, 28 AM. J.L. & MED. 409, 421 (2002).

to general medical care¹⁷⁷ without court intervention. Thus, a minor who becomes a member of the armed forces,¹⁷⁸ enters into a marriage or receives a divorce,¹⁷⁹ graduates from high school,¹⁸⁰ is pregnant,¹⁸¹ lives independently from his or her parents and is financially self-sufficient,¹⁸² or is homeless¹⁸³ may, by virtue of this status, consent to a broad range of medical interventions.¹⁸⁴

No state law permits minors to consent to PrEP therapy or any other pharmacological HIV prevention modality.¹⁸⁵ However, some de facto emancipation exceptions that permit minors to consent to general medical care coincide with the personal, family, or social circumstances of certain at-risk minors. At-risk minors who are unaccompanied, have no contact with or live independently of caregivers, refuse to seek parental consent, or could endure mental or physical abuse should the provider seek parental consent likely comprise a great deal of PrEP candidates. Thus, it is critical to consider how state law treats minors in these circumstances. If a state permits a minor to consent to his or her own general medical care in these situations, advocates are presented with an excellent opportunity

177 General medical care may include, but is not limited to, care for injuries, illnesses, exams, and sexual health issues. See *General Medical Care*, UNIV. OF OREGON, <https://healthcenter.uoregon.edu/Services/GeneralMedicalCare.aspx> [<https://perma.cc/UZ6Y-MH3E>] (last visited Nov. 20, 2015).

178 See, e.g., ME. REV. STAT. tit. 22, § 1503 (2015); MASS. GEN. LAWS ch. 112, § 12F (2015). See also Arshagouni, *supra* note 12, at 334; Hartman, *supra* note 176, at 422.

179 See, e.g., ALA. CODE § 22-8-4 (2015) (“Any minor who . . . is married, or having been married is divorced . . . may give effective consent to any legally authorized medical, dental, health or mental health services for himself or herself.”). See also Arshagouni, *supra* note 12, at 334; Hartman, *supra* note 176, at 421.

180 See, e.g., ALA. CODE § 22-8-4 (“Any minor who . . . has graduated from high school . . . may give effective consent . . .”); Hartman, *supra* note 176, at 421–22.

181 See, e.g., UTAH CODE ANN. § 78B-3-406 (West 2015) (“[A]ny female regardless of age or marital status, when given in connection with her pregnancy or childbirth,” may consent). See also Arshagouni, *supra* note 12, at 334; Hartman, *supra* note 176, at 421.

182 See *infra* Part II.A.2.a; Arshagouni, *supra* note 12, at 334; Hartman, *supra* note 176, at 422.

183 See, e.g., ARIZ. REV. STAT. ANN. § 44-132 (2015) (“[A]ny emancipated minor, any minor who has contracted a lawful marriage or any homeless minor may give consent to the furnishing of hospital, medical and surgical care to such minor . . .”). See Arshagouni, *supra* note 12, at 334; Hartman, *supra* note 176, at 421; *infra* Part II.A.2.f.

184 See Arshagouni, *supra* note 12, at 334.

185 Culp & Caucci, *supra* note 6, at 120.

to operationalize PrEP for broad spectrum of high-risk youth who would likely eschew preventive HIV care in the event that parental consent is required.

By statute, more than half of United States jurisdictions¹⁸⁶ permit certain minors to consent to general medical care, which by implication could include PrEP or other pharmacological HIV prevention modalities.¹⁸⁷ These statutory exceptions to the general rule that minors may not consent to their own medical care may be divided into six types: (1) separation and financial independence exceptions; (2) maturity exceptions; (3) mid-adolescence exceptions; (4) medical necessity exceptions; (5) parental unavailability or non-engagement exceptions; and (6) homeless youth exceptions.¹⁸⁸ Within this framework, I discuss each, and potential implications for operationalizing PrEP for self-consenting minors.

a. Separation and Financial Independence Exceptions

At least fifteen jurisdictions have statutes specifying that qualifying minors living separate and apart from their parents or guardians and “managing their own financial affairs” may consent on their own behalf to general medical care.¹⁸⁹ Some statutes do

186 Unlike the survey of STI consent statutes in this Article, research conducted in connection with de facto emancipation exceptions should be considered representative and not exhaustive. Additionally, research did not include a review of the laws of American territories, such as American Samoa, Guam, Puerto Rico, and the Virgin Islands. Research did not include regulations, state attorney general opinions, or case law.

187 *E.g.*, ALA. CODE § 22-8-4 (2015); ALASKA STAT. § 25.20.025 (2015); ARIZ. REV. STAT. ANN § 44-132(A); ARK. CODE ANN. § 20-9-602(7) (2015); CAL. FAM. CODE § 6922(a) (West 2015); COLO. REV. STAT. § 13-22-103(1)–(2) (2015); FLA. REV. STAT. § 743.067(3)(b) (2015); HAW. REV. STAT. §§ 577D-1, 577D-2(a) (2015); IDAHO CODE ANN. § 39-4503 (2015); 410 ILL. COMP. STAT. § 210/1.5 (2015); IND. CODE § 16-36-1-3(a)(2)(B) (i)–(iv) (2015); KAN. STAT. ANN. § 38-123B (2015); ME. REV. STAT. ANN. tit. 22, § 1503(1) (2015); MD. CODE ANN., HEALTH-GEN. § 20-102(a)(3)(i)–(ii) (West 2015); MASS. GEN. LAWS ch. 112, § 12F(v) (2015); MINN. STAT. § 144.341 (2015); MISS. CODE ANN. § 41-41-3(2) (2015); MO. REV. STAT. § 431.056 (2015); MONT. CODE ANN. 41-1-402(2) (2015); NEV. REV. STAT. § 129.030(1)(a) (2015); N.M. STAT. ANN. § 24-7A-6.2 (2015); OKLA. STAT. tit. 63, § 2602(A)(2) (2015); OR. REV. STAT. § 109.640(2)(a)–(b) (2015); S.C. CODE ANN. § 63-5-350 (2015); S.D. CODIFIED LAWS § 20-9-4.2 (2015); TEX. FAM. CODE ANN. § 32.003(a)(2)(A)–(B) (West 2015); WYO. STAT. ANN. § 14-1-101(b)(iii)–(iv) (2015).

188 There is some overlap between these categories. Alaska, for example, permits minor self-consent to general medical care if the minor is living separate and apart from his or her parents and is managing his or her own financial affairs, but also permits consent to general medical care if the parent or guardian cannot be contacted or the minor patient is unwilling to secure parental consent, as long as the provider counsels the minor patient as to the interests of the parent “as best as the provider assumes them.” ALASKA STAT. § 25.20.025(a)(2) (2015).

189 *E.g.*, ALASKA STAT. § 25.20.025; CAL. FAM. CODE § 6922(a); COLO. REV. STAT. § 13-22-103(1)–(2); IND. CODE § 16-36-1-3(a)(2)(B)(i)–(iv); ME. REV. STAT. ANN. tit. 22, § 1503(1); MD. CODE ANN., HEALTH-GEN. §

not specify the length of separation and financial independence.¹⁹⁰ In these jurisdictions, the exception may apply not just to those minors with sufficient financial means to live independently, but also to minors who are homeless, unstably housed, runaways, castaways, or living on the street, as long as those minors do not currently live with their parents or guardians and are not reliant upon them for financial assistance. On the other hand, it is unclear what the language “managing” one’s own “financial affairs” means. Is it sufficient if the adolescent is currently not receiving financial assistance from a parent or guardian? What if the unaccompanied minor receives financial assistance from a friend? If the legislative purpose of these exceptions is to pinpoint a narrow category of minors who have demonstrated histories of financial responsibility and self-sufficiency, this may run counter to the argument that homeless, unstably housed, runaway, or castaway youth may self-consent pursuant to this exception. Advocates, particularly in states that do not have a dedicated consent law pertaining to homeless youth, should seek clarification about such laws as they relate to unstably housed youth and consider whether operationalizing PrEP for unaccompanied, self-consenting youth pursuant to this exception is consistent with its legislative purpose.

b. Maturity Exceptions: Statutory and Common Law

A minority of United States jurisdictions—including Arkansas, Idaho, Illinois, and Hawaii—permit minors with sufficient cognitive maturity to consent to general medical care without the consent of a third party via statute.¹⁹¹ Arkansas, for example, permits “any unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures, [to consent] for himself or herself.”¹⁹² Idaho declares that “[a]ny person who comprehends the need for, the nature of and the significant risks ordinarily inherent in any contemplated hospital,

20-102(a)(3)(i)–(ii); MASS. GEN. LAWS ch. 112, § 12F(v); MINN. STAT. § 144.341; MO. REV. STAT. § 431.056; MONT. CODE ANN. §§ 41-1-401(1)(b), 41-1-402(2)(b) (2015); NEV. REV. STAT. § 129.030(1)(a); N.M. STAT. ANN. § 24-7A-6.2(A)(1); OKLA. STAT. tit. 63, § 2602(A)(2); TEX. FAM. CODE ANN. § 32.003(a)(2)(A)–(B); WYO. STAT. ANN. § 14-1-101(b)(iv).

190 See, e.g., CAL. FAM. CODE § 6922(a)(2)–(3) (permitting qualifying minors who manage their own financial affairs to consent without regard to duration or source of income).

191 ARK. CODE ANN. § 20-9-602(7); HAW. REV. STAT. §§ 577D-1, 577D-2(a)(1); IDAHO CODE ANN. § 39-4503; 410 ILL. COMP. STAT. § 210/1.5(a)(1) (2015); see generally Moore et al., *supra* note 6, at 41 (noting that “[s]ome states have adopted the mature minor doctrine, which permits a minor to consent to or refuse care if it is established that the minor is mature enough to understand and appreciate the benefits and risks of that care”).

192 ARK. CODE ANN. § 20-9-602(7).

medical, dental, surgical or other health care, treatment or procedure is competent to consent thereto on his or her own behalf.”¹⁹³ Illinois permits a minor to consent to general care if the primary care physician believes the minor understands the risks and benefits, and is identified as seeking care by a social services agency, attorney, or other adult decision maker.¹⁹⁴

A greater number of United States jurisdictions—including Connecticut, the District of Columbia, Illinois, Kansas, Maine, Massachusetts, Michigan, Mississippi, Tennessee, and West Virginia—permit minors with sufficient maturity to consent to general medical care without parental involvement via common law.¹⁹⁵ Under the mature minor doctrine at common law, the court determines, as a matter of fact, whether the minor has sufficient cognitive capacity to consent to medical treatment, taking into consideration factors such as the minor’s age, apparent age, evidence of responsible behavior (outside and inside the provider setting), and evidence of reasoned decision making.¹⁹⁶ In determining whether a minor had sufficient maturity to consent to care and immunize a provider from liability, the Tennessee Supreme Court articulated the following test:

193 IDAHO CODE ANN. § 39-4503.

194 410 ILL. COMP. STAT. § 210/1.5.

195 See *Kozup v. Georgetown Univ.*, 851 F.2d 437, 439 (D.C. Cir. 1988) (recognizing the mature minor exception in dicta); *In re Cassandra C.*, 112 A.3d 158, 160 (Conn. 2015) (applying mature minor concept to find provider had not met burden to show seventeen-year-old had sufficient maturity to refuse life-saving medical treatment); *In re E.G.*, 549 N.E.2d 322, 328 (Ill. 1989) (“[M]ature minor may exercise a common law right to consent to or refuse medical care”); *In re Swan*, 569 A.2d 1202, 1206 (Me. 1990) (finding high school senior had sufficient maturity to effectuate his “well-formed desires” to order the removal of his feeding tube); *Younts v. St. Francis Hosp. & Sch. of Nursing*, 469 P.2d 330, 338 (Kan. 1970) (recognizing doctrine in context of doctor who performed surgery on finger of seventeen-year-old teenager without parental consent, as minor “was mature enough to understand the nature and consequences and to knowingly consent to the . . . [necessary] surgical procedure”); *In re Rena*, 705 N.E.2d 1155, 1157 (Mass. 1999) (court “consider[s] the maturity of the child to make an informed choice” in the context of refusal of medical treatment by parent); *Bakker v. Welsh*, 108 N.W. 94, 96 (Mich. 1906) (seventeen-year-old could self consent to non-emergency operation); *Gulf & Ship Island R.R. Co. v. Sullivan*, 119 So. 501, 502 (Miss. 1928) (finding provider reliance on consent of seventeen year old who was able to “understand and appreciate” the consequences of vaccination precluded liability); *Cardwell v. Bechtol*, 724 S.W.2d 739, 746 (Tenn. 1987); *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 837–38 (W. Va. 1992) (holding “the mature minor exception is part of the common law rule of parental consent,” and recognizing the doctrine must be applied in a case-by-case nature). One state—Pennsylvania—has explicitly rejected the doctrine. See *Comm. v. Nixon*, 761 A.2d 1151, 1156 (Pa. 2000) (rejecting in context of a sixteen-year-old adolescent who refused medical intervention), *cert. denied*, 532 U.S. 1008 (2001).

196 See *Cardwell*, 724 S.W.2d at 739. See also THOMAS A. JACOBS, 2 CHILDREN AND THE LAW: RIGHTS & OBLIGATIONS § 10.7 (2015).

[w]hether a minor has the capacity to consent to medical treatment depends upon the age, ability, experience, education, training, and degree of maturity or judgment obtained by the minor, as well as upon the conduct and demeanor of the minor at the time of the incident involved. Moreover, the totality of the circumstances, the nature of the treatment and its risks or probable consequences, and the minor's ability to appreciate the risks and consequences are to be considered.¹⁹⁷

In jurisdictions adopting the mature minor doctrine at common law, providers seeking to develop policies regarding PrEP for youth should first consider their liability dimensions in consultation with legal counsel. While common law maturity exceptions have been affirmed in connection with controversial treatments such as a minor's right to refuse lifesaving treatment¹⁹⁸ and other prophylaxes such as vaccination,¹⁹⁹ PrEP therapy is neither treatment refusal nor a one-time dosage. In fact, PrEP exposes the youth patient to enduring risks of side effects and tolerability issues. Moreover, it is unclear how courts would employ the maturity exception in off-label prescription of Truvada as PrEP for youth, especially since there is currently little clinical research confirming its safety and efficacy in the youth population. Thus, even in states with long-established common law mature minor doctrines, providers should proceed with caution.

In jurisdictions adopting the mature minor doctrine via statute, youth of sufficient maturity may theoretically consent to their own healthcare, including PrEP, without first seeking the intervention of a court.²⁰⁰ It is unclear, however, whether these statutes would require an adjudication that a particular minor is, in fact, sufficiently mature. A provider who relies on a minor's consent to PrEP pursuant to a mature minor statute that has not been the subject of judicial review may only know the statute's liability dimensions after a civil or criminal lawsuit is filed against them, or an adverse court ruling is issued.

Notwithstanding these concerns, permitting the physician to assess the competence of a minor on an individual basis makes sense. It is consistent with recent trends to lower the age of consent in matters of sexual healthcare and with the highly individualistic nature

197 *Cardwell*, 724 S.W.2d at 748.

198 *E.g.*, *Swan*, 569 A.2d at 1206; *Rena*, 705 N.E.2d at 1157; *Cassandra C.*, 112 A.3d at 160.

199 *E.g.*, *Gulf & Ship Island R.R. Co.*, 119 So. at 502.

200 Maureen Carroll, *Transgender Youth, Adolescent Decisionmaking, and Roper v. Simmons*, 56 U.C.L.A. L. REV. 725, 739–40 (2009).

of sexual healthcare. Additionally, these exceptions further the important legislative goal of ensuring adequate healthcare for youth. Furthermore, maturity exceptions that provide immunity for providers who rely on the self-consent of minors upon a finding of sufficient maturity incentivize medical professionals to foster substantive conversations with minors in matters where a minor would sooner forego care altogether than seek the permission of an adult caregiver.

Thus, while not the surest means of ensuring minor access to PrEP without parental consent, these exceptions are worthy of future exploration.

c. Mid-Adolescence Exceptions

A small minority of states—for example, Alabama, Kansas, and Oregon—permit minors to consent to general medical care if they are mid-adolescents.²⁰¹ These statutory exceptions set various age minimums. For example, Alabama permits minors fourteen years of age or older to consent to general medical care.²⁰² Kansas permits minors sixteen years of age or older to consent to general medical care.²⁰³ Oregon permits minors fifteen years of age and older to consent to general medical care.²⁰⁴ In states with exceptions permitting mid-adolescents to consent to general medical care, by implication, at-risk mid-adolescents may consent to pharmacological HIV prevention, including PrEP, without the consent of a third party.²⁰⁵ Permitting mid-adolescents to self-consent to PrEP pursuant to

201 *E.g.*, ALA. CODE § 22-8-4 (2015); KAN. STAT. ANN. § 38-123B (2015); OR. REV. STAT. § 109.640 (2) (2015). Common law and state attorney general opinions may also effectively permit minors in mid-adolescence to consent to general medical care. *See, e.g., Cardwell*, 724 S.W.2d at 749 (creating a presumption that minors between age fourteen and eighteen have the capacity to self-consent to medical treatment); Tenn. Op. Att’y Gen. No. 03-087 (2003) (affirming *Cardwell* presumption). However, an extensive review of common law and attorney general opinions is beyond the scope of this Article.

202 ALA. CODE § 22-8-4.

203 KAN. STAT. ANN. § 38-123B.

204 OR. REV. STAT. § 109.640.

205 It is important to acknowledge that these exceptions do not capture youth in early adolescence engaging in HIV-related risk behavior. This may have a greater impact on minority youth than non-minority youth. For example, African American youth tend to “engage in sexual behaviors earlier than Caucasians, with significant sexual pressure beginning in the junior years.” ADOLESCENCE: DEVELOPMENT DURING A GLOBAL ERA 352 (Dena Phillips Swanson et al. eds., 2010). Additionally, African American youth face an elevated risk of HIV infection. *See id.* (noting that African American adolescents comprise sixty-one percent of HIV infections among the age group despite comprising only fifteen percent of the total adolescent population). Together, these psychosocial

these exceptions is consistent with the science of adolescent risk-taking, as HIV-related risk behavior is at its apex during mid-adolescence and is unlikely to be remedied with traditional HIV prevention methods such as behavioral modification.

d. Medical Necessity Exceptions

Medical necessity exceptions permit minors to consent to general medical care if, in the provider's judgment, the service is necessary. Research conducted in connection with this Article indicates that the only state currently permitting minors to consent to any general medical care the physician deems necessary is South Carolina.²⁰⁶

By virtue of this broad exception, providers in South Carolina may furnish health services if the provider determines that care is necessary. However, the statute does not specify what types of services may be necessary. Nonetheless, for those at-risk youth with a history of intermittent, improper, or nonuse of condoms or a history of sharing syringes, a physician may determine that PrEP is, in fact, necessary as a minimum layer of protection against HIV infection.

South Carolina, which has a greater rate of sexual risk behavior among youth than the national average,²⁰⁷ is an excellent state for PrEP advocacy among minors. Youth healthcare advocates in other jurisdictions should consider using South Carolina's statute as a model for drafting medical necessity exceptions in their own jurisdictions. Medical necessity exceptions are legislative reflections of the significant deference courts grant to the treating physician's individual assessment of medical necessity in coverage determinations.²⁰⁸

and epidemiological factors indicate that African American youth may need access to effective HIV prevention earlier.

206 S.C. CODE ANN. § 63-5-350 (2015) ("Health services of any kind may be rendered to minors of any age without the consent of a parent or legal guardian when, in the judgment of a person authorized by law to render a particular health service, such services are deemed necessary unless such involves an operation . . .").

207 For example, South Carolina ranks higher than the national average in the percentage of high-school students who have had sex (57% and 47%, respectively), almost double the percentage of high school students who had intercourse for the first time before age thirteen than the national average (11% and 6%, respectively), higher than the national average in the percentage of high school students who have had sex with more than four people (21% and 15%, respectively), and higher than the national average in the number of high school students who consumed drugs or alcohol before their last sexual intercourse (26% and 22%, respectively). U.S. DEP'T OF HEALTH & HUM. SERVS., SOUTH CAROLINA ADOLESCENT REPRODUCTIVE HEALTH FACTS 5 (2011), <http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/states/pdfs/sc.pdf> [<http://perma.cc/59NN-5TRZ>].

208 See Underhill, *supra* note 3, at 649. For extensive discussion of medical necessity in the context of

These exceptions touch all aspects of healthcare for minors, and foster active engagement between patients and physicians.

e. Parental Unavailability or Non-Engagement Exceptions

A minority of states permit medical care to be furnished to minors in the event that a parent is not “immediately available,” “reasonably available,” or otherwise reachable.²⁰⁹ Alaska’s statute is notable, specifying that:

a minor may give consent for medical and dental services if the parent or legal guardian . . . cannot be contacted or, if contacted, is unwilling either to grant or withhold consent; however, where the parent or legal guardian cannot be contacted or, if contacted, is unwilling either to grant or to withhold consent, the provider of medical or dental services shall counsel the minor keeping in mind not only the valid interests of the minor but also the valid interests of the parent or guardian and the family unit as best the provider presumes them.²¹⁰

In Alaska, if an at-risk minor is unable to provide the contact information of an adult with decision-making authority (for example, if the minor is orphaned or a castaway), by implication the provider may rely on the consent of the minor to prescribe PrEP upon considering the purported interests of the minor’s caregiver. It is unclear, however, how a provider should proceed if a minor refuses to provide the contact information of an adult decision maker (say, if the minor is a runaway and fears parental retaliation). Clarification is needed. Additionally, should the minor provide such contact information and the adult decision maker is unresponsive or declines to either give or refuse consent, the Alaska statute implies that the physician may rely on the minor’s self-consent to PrEP upon consideration of the various interests involved.²¹¹ Alaska’s statute is also notable in that it encourages the physician to consider the interests of the parents “as best as the provider

biomedical HIV prevention, see *id.* at 647–53; Burda, *supra* note 3, at 203–14.

209 *E.g.*, ALASKA STAT. § 25.20.025(a)(2) (2015); KAN. STAT. ANN. § 38-123b (2015); MISS. CODE ANN. § 41-41-3(2) (2015) (specifying minors age sixteen and older); S.D. CODIFIED LAWS § 20-9-4.2 (2015); WYO. STAT. ANN. § 14-1-101(b)(iii) (2015); see generally Moore, *supra* note 6, at 41 (noting that some states “grant minors general authority to consent to health care when parents are unavailable or unwilling to provide consent or when the minor is over a particular age threshold”).

210 ALASKA STAT. § 25.20.025(a)(2).

211 *Id.*

presumes them.” This clause invites speculation by physicians about how parents would react to the proffered care and shifts the focus from the *real* interests of the youth before them to the provider’s *imagined* interests of absent parents.

Nonetheless, statutory exceptions permitting minors to consent to general medical care in the event of parental absence, such as Alaska’s statute, may provide an avenue for minor self-consent to PrEP. Lawmakers in jurisdictions without such exceptions should consider incorporating these exceptions with careful attention to spotlighting the interests of youth, considering the actual interests of parents (if articulated), and discouraging speculation about unconfirmed parental concerns. Furthermore, these exceptions reflect the current scientific understanding of behavioral changes during adolescence that strain parent-child relationships. These exceptions also reflect the harsh realities of some marginalized youth whose parents would sooner bury their heads in the sand than engage with providers about their child’s unique sexual healthcare needs, or those minors for whom survival depends upon secrecy.

f. Homeless Youth Exceptions

Homeless youth laws are concerted legislative efforts to serve the healthcare needs of marginalized youth. Arizona and Florida, for example, explicitly permit homeless youth to consent to general medical care.²¹² In its 1991 amendment to the minor consent statute, the Arizona Legislature added a provision permitting “any homeless minor [to] give consent to the furnishing of hospital, medical and surgical care to such minor.”²¹³ The statute defines a homeless minor as an individual under eighteen “living apart from his parents and who lacks a fixed and regular nighttime residence or whose primary residence is either a supervised shelter . . . , a halfway house or a place not designed for or ordinarily used for sleeping by humans.”²¹⁴ In Arizona, providers serving unstably housed youth at high risk of HIV infection may be able to rely on the self-consent of those youths to administer PrEP prevention without regard to the age of the adolescent. On the other hand, given that PrEP is a comprehensive treatment regimen, the continuation of which requires refill prescriptions, monitoring, and supervision, it is unclear whether a minor who effectively consented to PrEP therapy while unstably housed would be able to continue the therapy without parental involvement if he or she locates more permanent housing mid-therapy. If continuation of therapy is contingent upon remaining homeless or unstably housed, then

212 ARIZ. REV. STAT. ANN. § 44-132(A) (2015); FLA. STAT. § 743.067(3)(b) (2015).

213 ARIZ. REV. STAT. ANN. § 44-132(A).

214 *Id.*

furnishing PrEP to runaway or castaway youth who value continuing it could actually disincentivize them from seeking stable housing and reconciliation with parents, guardians, or adult caregivers. It is possible that Arizona legislators could remedy this uncertainty by amending its existing statute.

Apart from this uncertainty, Arizona's statute may be seen as a model for other states considering how to better meet the privacy and healthcare concerns of marginalized, often invisible youth. Lawmakers in jurisdictions with the greatest shares of homeless youth—most notably California²¹⁵—should consider amending existing consent statutes to add this exception. This, in turn, could enable confidential access to the full range of HIV prevention methods for a great number of unstably housed, at-risk youth.

h. Putting the Framework into Action

This exercise of disaggregating de facto emancipation exceptions that permit minors to consent to general medical care and grouping them by personal, family, and social circumstance is a useful tool for advocates and policymakers considering whether their state statutes meet the privacy needs of at-risk minors in sensitive healthcare matters. It also provides an advocacy framework for those considering potential avenues to operationalizing PrEP and other pharmacological prevention modalities for at-risk minors without parental consent. Disaggregating these exceptions can help eliminate confusion and inaccuracies. In fact, one recent, peer-reviewed study of laws permitting minor consent to general medical care that aggregated de facto emancipation exceptions²¹⁶ was both under-inclusive and inaccurate.²¹⁷

215 As of 2013, the U.S. Department of Housing and Urban Development (HUD) estimated that California had the highest number of unaccompanied homeless youth (UHY), with more than four times the number of UHY than New York (n=15,469, n=3,670). See U.S. DEP'T OF HOUSING & URBAN DEV., ANNUAL HOMELESS ASSESSMENT REPORT (AHAR) TO CONGRESS 49 (2013), <https://www.hudexchange.info/resources/documents/ahar-2013-part1.pdf> [<http://perma.cc/44V8-W4TU>].

216 See, e.g., Doriane Lamberlet & Phillip Rosoff, *The Legal Authority of Mature Minors to Consent to General Medical Treatment*, 131 PEDIATRICS 786, 790–91 Tbl.1 (2013), <http://pediatrics.aappublications.org/content/131/4/786.full.pdf> [<http://perma.cc/MWZ6-TS76>] (aggregating mid-adolescence exceptions, parental unavailability exceptions, emergency exceptions, mature minor case law, and attorney general opinions).

217 Lamberlet and Rosoff's 2013 study published in *Pediatrics* was both under-inclusive and imprecisely conveyed the scope of care to which a minor may consent. Compare *id.* at Tbl.1 with Tbls.1–3, *infra* at 359–64. For example, pursuant to Delaware's emergency exception, minors may only consent, after reasonable efforts to secure the consent of a parent or guardian, to specific care: treatment of traumatic injury and treatment of a "symptom, disease or pathology which may, in the judgment of the attending personnel preparing such treatment, if untreated, reasonably be expected to threaten the health or life of such minor." DEL. CODE ANN. tit. 13, § 707(b)(5) (West 2015). However, Lamberlet and Rosoff represented Delaware's statute as permitting

Thus, further reviews of state emancipation statutes based on this framework are needed.

As I concluded with respect to the survey of STI consent statutes herein, what this exercise also reveals is a deep discord among the states about confidential access to care for minors. This discord, along with provider confusion that can result in the delay of critical healthcare services, are justifications for the development of federal solutions that set national policies on confidential access to care for minors.²¹⁸

3. Furnishing PrEP Pursuant to Emergency Exceptions

In addition to state exceptions permitting minors to consent to general medical care, there are a number of state exceptions permitting physicians to act without parental consent in more limited scenarios. One of these scenarios is the emergency. Almost all states “recognize the need for medical professionals to render emergency treatment to minors free from the specter of civil liability for failure to obtain informed consent from parents,”²¹⁹ either by common law or enacted law.²²⁰ This exception to the general rule that minors may not consent to their own medical care is service-specific, applying only to treatment in connection with emergencies. This is unlike emancipation exceptions, which apply to general medical care. Emergency exceptions are also unlike emancipation exceptions, which typically give certain minors adult capacity, because emergency exceptions do not grant the minor these rights. In exigent circumstances, parental consent is implied.²²¹

The majority of United States jurisdictions have statutes specifically pertaining to

minor consent to *general* medical care, which is inaccurate. In Delaware, care may only be offered in connection with a specific injury or “symptom, disease or pathology.” This could cause provider confusion about a minor’s ability to consent to prophylactic care, which does not exist to treat a specific injury, symptom, or disease, but rather exists to prevent it.

218 See Hartman, *supra* note 176, at 426 (advocating for “[f]ederal legislation to establish a unified, national policy regarding adolescent decision-making capability” and observing that “by recognizing decision-making ability of adolescents, the policy would be responsive to the reality of adolescent cognitive development and to the particular needs of adolescents, separate and apart from younger children”).

219 JACOBS, *supra* note 196, at § 10.5.

220 Research conducted in connection with statutory emergency exceptions should be considered representative and not exhaustive. Regulations cited herein should also be considered representative. Additionally, I did not review the common law dimensions of emergency treatment of minors without parental consent.

221 See RICHARD W.O. BEEBE & DEBORA L. FUNK, *FUNDAMENTALS OF EMERGENCY CARE* 36 (2001) (noting that “in . . . emergent cases, the law assumes that the parents would want their seriously ill or injured child to be treated [, and] [s]uch treatment would be possible under implied consent”).

emergency treatment of minors.²²² Among the fifty states (and the District of Columbia), there exist two types of statutory emergency exceptions: broad and narrow. Both broad and narrow statutory exceptions remove the consent requirement and are silent as to whether the minor may self-consent in these situations.²²³ Additionally, both include three dimensions: (1) the severity of the injury and/or the potential effect of delaying care; (2) who may provide services; and (3) the type of care that can be rendered.

In this section, I consider each of these dimensions in broad and narrow emergency exceptions. I apply the two types of exceptions to minor consent to PrEP and argue that, in states with broad emergency exceptions, it would be possible to frame PrEP as an emergency. I introduce the concept of a “PEP to PrEP pipeline,” the idea that an at-risk minor who believes he or she was exposed to HIV may be treated with *post*-exposure prophylaxis (PEP), a thirty day course of ARV treatment (which could include Truvada), under the emergency exception without securing parental consent. After the thirty-day course of supervised PEP treatment, medical documentation of tolerability, and confirmation of HIV-negative status, the option of continuing treatment with Truvada as PrEP may be swiftly introduced.

The first dimension of statutory emergency exceptions is a limitation on the nature and severity of the medical issue. In jurisdictions with broad statutory definitions of the medical dimension, a provider may furnish emergency care if the life or health of the minor is in peril. In the District of Columbia, for example, a licensed physician or dentist may provide “health services” to a minor of any age without parental consent if the provider determines that “the delay that would result from attempting to obtain parental consent would substantially increase the risk to the minor’s life, health, mental health, or welfare, or would unduly prolong suffering.”²²⁴ This exception does not specify the nature of injury for which emergency services are sought. Rather, the provider may furnish care if he or she believes that seeking parental consent would have the effect of “substantially” elevating the risk to the minor’s wellbeing, with respect to “life, health, mental health, *or* welfare.”²²⁵ The District of Columbia regulation implies that a provider could furnish PrEP if there is a major chance (or the provider is certain) that the minor will be exposed to HIV during the

222 According to research conducted for this Article, states with no statutory emergency exception include Hawaii, Idaho, Indiana, Iowa, Kansas, Maine, Michigan, Ohio, Oregon, Rhode Island, Texas, Utah, Vermont, Washington, Wisconsin, and Wyoming.

223 See Jacobs, *supra* note 196, at § 10.5.

224 D.C. MUN. REGS. tit. 22-B, § 600.4 (2015).

225 *Id.* (emphasis added).

delay caused by seeking parental consent, or if there is a major chance (or the provider is certain) that the minor will experience violence or disownment should the provider notify parents and “out” him or her.²²⁶ In jurisdictions with broad injury dimensions such as this,²²⁷

226 Consultation of case law would be necessary.

227 ALA. CODE § 22-8-3 (2015) (“Any legally authorized medical, dental, health or mental health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the physician’s judgment, an attempt to secure consent would result in delay of treatment which would increase the risk to the minor’s life, health or mental health.”); CONN. GEN. STAT. § 17a-81(a) (2015) (“In the event [parental] consent is withheld or immediately unavailable and the physician concludes that treatment is necessary to prevent serious harm to the child, such emergency treatment may be administered pending receipt of parental consent.”); GA. CODE ANN. § 31-9-3 (a)(2) (West 2015) (providing an exception for when “a person authorized to consent [for a minor] is not readily available and any delay in treatment could reasonably be expected to jeopardize the life or health of the person affected or could reasonably result in disfigurement or impaired faculties”); KY. REV. STAT. ANN. § 214.185(4) (West 2015) (“Medical, dental, and other health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the professional’s judgment, the risk to the minor’s life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment.”); MD. CODE ANN., HEALTH-GEN. § 20-102(b) (West 2015) (“A minor has the same capacity as an adult to consent to medical treatment if, in the judgment of the attending physician, the life or health of the minor would be affected adversely by delaying treatment to obtain the consent of another individual.”); MINN. STAT. § 144.344 (2015) (“Medical, dental, mental and other health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the professional’s judgment, the risk to the minor’s life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment.”); NEV. REV. STAT. § 129.030(1)(d) (2015) (“In a physician’s judgment, in danger of suffering a serious health hazard if health care services are not provided.”); N.Y. PUB. HEALTH LAW § 2504(4) (McKinney 2015) (“Medical, dental, health and hospital services may be rendered to persons of any age without the consent of a parent or legal guardian when, in the physician’s judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person’s life or health.”); OKLA. STAT. ANN. tit. 63 § 2602.7 (West 2015) (“Any minor in need of emergency services for conditions which will endanger his health or life if delay would result by obtaining consent from his spouse, parent or legal guardian.”); 35 PA. CONS. STAT. § 10104 (2015) (“Medical, dental and health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the physician’s judgment, an attempt to secure consent would result in delay of treatment which would increase the risk to the minor’s life or health.”); S.C. CODE ANN. § 63-5-350 (2015) (“Health services . . . may be rendered to minors of any age without the consent of a parent or legal guardian when, in the judgment of a person authorized by law to render a particular health service, such services are deemed necessary unless such involves an operation which shall be performed only if such is essential to the health or life of such child”); S.D. CODIFIED LAWS § 20-9-4.2 (2015) (“A minor . . . may be treated by a licensed physician before the minor’s parent’s or guardian’s consent is obtained if a parent or guardian is not immediately available and if, in the opinion of the treating physician . . . , the attempt to secure the consent would result in delay of treatment which would threaten the minor’s life or health.”); TENN. CODE ANN. § 63-6-222(a) (2015) (“Any licensed physician may perform emergency medical or surgical treatment on a minor, despite the absence of parental consent or court order, where such physician has a good faith belief that delay in rendering emergency care would, to a reasonable degree of medical certainty, result in a serious threat to the life of the minor or a serious worsening of such

a provider could furnish care in a range of harm reduction scenarios, including PrEP, where in the event of delay, the risk of serious harm to the minor's wellbeing is substantial.²²⁸

On the other hand, jurisdictions that narrowly define the nature and scope of the emergency typically limit the exception to scenarios where the minor is suffering from a material and morbid illness, disease, pathology, or condition,²²⁹ and when death or serious injury is imminent.²³⁰ Because narrow emergency exceptions specify that care must be administered in connection with a condition, illness, injury, or disease, by implication, treatment in connection with *preventing* a condition, illness, injury, or disease falls outside the scope of emergency exceptions with narrow injury dimensions.²³¹ When care is furnished in connection with an illness that has not yet occurred or when the patient is asymptomatic, the patient cannot be said to be suffering from any present condition. Thus, advocates may have more difficulty operationalizing PrEP—prescribed to asymptomatic, HIV-negative individuals—for minors pursuant to emergency exceptions with narrow

minor's medical condition and that such emergency treatment is necessary to save the minor's life or prevent further deterioration of the minor's condition.”).

228 Unlike other jurisdictions with broad injury dimensions, in the District of Columbia, an argument may be made that if, in the physician's judgment, the attempt to secure consent would likely result in physical or emotional abuse or violence by a third party, the provider may render services without consent. This is useful in the case of child abuse, endangerment, and neglect.

229 *E.g.*, DEL. CODE ANN. tit. 13, § 707(b)(5) (West 2015):

Consent . . . may be given by . . . [a] minor . . . for the examination and treatment of (i) any laceration, fracture or other traumatic injury suffered by such minor, or (ii) any symptom, disease or pathology which may, in the judgment of the attending personnel preparing such treatment, if untreated, reasonably be expected to threaten the health or life of such minor; provided, however, that the consent given shall be effective only after reasonable efforts shall have been made to obtain the consent of the parent or guardian of said minor.

230 *E.g.*, MO. REV. STAT. § 431.063 (2015) (“For the purposes hereof, an emergency is defined as a situation wherein, in competent medical judgment, the proposed surgical or medical treatment or procedures are immediately or imminently necessary and any delay occasioned by an attempt to obtain a consent would reasonably jeopardize the life, health or limb of the person affected, or would reasonably result in disfigurement or impairment of faculties.”); MONT. CODE ANN. § 41-1-405 (1) (2015) (“A health professional may render or attempt to render emergency service or first aid, medical, surgical, dental, or psychiatric treatment, without compensation, to any injured person or any person regardless of age who is in need of immediate health care when, in good faith, the professional believes that the giving of aid is the only alternative to probable death or serious physical or mental damage.”); N.C. GEN. STAT. ANN. § 90-21.1(4) (West 2015) (“necessary to prevent immediate harm to the child”).

231 *See generally* Burda, *supra* note 3, at 207–08 (investigating this issue in the context of insurance benefit denials).

injury dimensions.²³²

However, if a provider diagnoses the minor with “exposure to HIV,” this may permit the provider to furnish Truvada as PEP (as opposed to PrEP) without parental consent. In the event a minor is actually exposed to HIV (e.g., if the minor has condomless, receptive anal sex with a known HIV-positive, virally unsuppressed partner) or is *likely* exposed to HIV (e.g., if the minor has condomless, receptive anal sex with a partner in a high HIV prevalence group of unknown status), PEP should administered within seventy-two hours to avoid potential infection. Given the significant risk of delaying PEP, administering Truvada as PEP may fall within the scope of the injury dimension of emergency exceptions. As such, a potential avenue for PrEP access is to begin treatment as PEP and then convert treatment to PrEP.²³³ Thus, even if a jurisdiction’s emergency exception has a narrow injury

dimension, it may be possible to use the exception as a means to deliver confidential PrEP

232 Whether the injury dimension would permit minor access to PrEP without express parental consent is refined by case law. Courts appear more likely to find that a scenario is an emergency, warranting bypass of parental consent, if the delay in care caused by securing parental consent would likely result in imminent serious harm or death. *See* Tabor v. Scobee, 254 S.W.2d 474, 477 (Ky. 1951) (despite eventual effect of delaying removal of fallopian tubes could have been death within six months, death was not imminently likely). *But see* Piedra v. Dugan, 123 Cal. App. 4th 1483, 1491 (Cal. Ct. App. 2004) (treatment of infant’s prolonged seizure without parental consent seizure justified as emergency); Luka v. Lowrie, 136 N.W. 1106, 1109 (Mich. 1912) (instant amputation was necessary to preserve life for fifteen-year-old boy). In interpreting its own emergency exception, the Supreme Court of Texas stated the following about the severity of the condition: “[T]he emergent circumstances exception acknowledges that the harm from failing to treat outweighs any harm threatened by the proposed treatment . . . because the harm from failing to provide life-sustaining treatment under emergent circumstances is death.” *Miller ex rel. Miller v. HCA, Inc.*, 118 S.W.3d 758, 768 (Tex. 2003). California has a broader test for whether an emergency exists. The court asks “whether the undisputed facts establish the existence of an exigency of ‘so pressing a character that some kind of action must be taken.’” *Bryant v. Bakshandeh*, 226 Cal. App. 3d 1241, 1247 (Cal. Ct. App. 1991) (quoting *Kearns v. Super. Court*, 204 Cal. App. 3d 1325, 1328 (Cal. Ct. App. 1988)). This suggests that determining whether an emergency exists involves a balancing test. Parental consent may be implied pursuant to emergency exceptions if the risk of serious harm or death caused by delaying care to secure parental consent is greater than the risk of the care itself. Applying this test to PrEP for minors, the risk of serious harm to the minor (HIV infection) caused by delaying therapy may not outweigh the risk of prescription of Truvada as PrEP because, while failing to provide PrEP to the minor may *eventually* lead to HIV infection, infection is not the *imminent*, probable consequence. Additionally, given that PrEP is administered in perpetuity, the risks inherent in the therapy are ongoing and not singular in their occurrence.

233 However, there are a number of questions about the implications of continuing PEP as PrEP. For example, must the provider seek consent from a parental figure once Truvada is continued as PrEP? Is the consent of a parent figure required as a result of the addition of the periodic monitoring, testing, and refill prescriptions required when the limited course of PEP treatment turns into the continuous therapy of PrEP? Is a new coded diagnosis required at all?

access to youth.

While the first dimension of emergency is nuanced, the second dimension of statutory emergency exceptions is less so. Emergency exceptions also include a limitation on who may provide emergency treatment to the minor.²³⁴ Jurisdictions with broad caregiver dimensions permit a broad range of healthcare professionals to furnish care.²³⁵ This may be interpreted as including advanced practice nurses, emergency medical technicians, physician's assistants, and other non-physician healthcare workers. Conversely, jurisdictions with narrow caregiver dimensions limit those professionals who may furnish care to physicians,²³⁶ and some include dentists and surgeons.²³⁷ While the caregiver dimension involves little interpretation, it is important to consider its implications for PrEP. Some providers serving at-risk youth may be staffed solely by advance practice nurses who may prescribe PrEP but may nonetheless be unable to provide services according to this exception should the jurisdiction limit those who may act to licensed physicians.

The third dimension of statutory emergency exceptions is a limitation on the type of care that can be furnished.²³⁸ Broader statutes define these services in an expansive

234 This dimension lacks a common law layer.

235 See, e.g., MINN. STAT. § 144.344 (2015):

Medical, dental, mental and other health services may be rendered to minors of any age without the consent of a parent or legal guardian when, *in the professional's judgment*, the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment.

(emphasis added).

236 See, e.g., MD. CODE ANN., HEALTH GEN. § 20-102(b) (West 2015) ("in the judgment of the attending physician"); NEV. REV. STAT. § 129.030(1)(d) (2015) ("physician's judgment"); N.Y. PUB. HEALTH LAW § 2504(4) (McKinney 2015) ("in the physician's judgment").

237 E.g., D.C. MUN. REGS. tit. 22-B, § 600.4 (2015).

238 Courts interpreting emergency exceptions tend to specify that the standard of care administered in such situations is "that which the occasion demands within the usual and customary practice among physicians in the same locality." See *Sullivan v. Montgomery*, 279 N.Y.S. 575, 577 (N.Y.C. Civ. Ct. 1935). Accord *Wheeler v. Barker*, 208 P.2d 68, 71 (Cal. Ct. App. 1949); *Jackovach v. Yocom*, 237 N.W. 444, 449 (Iowa 1931). But cf. *Rogers v. Sells*, 61 P.2d 1018, 1019 (Okla. 1936) (accepting testimony of medical expert that appropriate course of action for physicians confronted with leg fracture is not amputation when main blood vessel is not destroyed).

manner, specifying that “health services” can be furnished.²³⁹ Narrower emergency exceptions specify that “treatment,” “medical treatment,” or “surgical treatment” can be furnished.²⁴⁰ PrEP therapy may readily be considered a health service in jurisdictions with broad care dimensions. On the other hand, if a jurisdiction limits the type of care to medical “treatment,” whether PrEP may be furnished could depend on whether PrEP is considered a treatment.²⁴¹

An analysis of each of these dimensions of emergency exceptions reveals that, while it may be theoretically possible to frame PrEP therapy as an emergency and thereby bypass parental consent, there are a number of uncertainties to explore before doing so.²⁴² Providers

239 *E.g.*, ALA. CODE § 22-8-3 (2015) (“[a]ny legally authorized medical, dental, health or mental health services”); CAL. BUS. & PROF’L CODE § 2397(c)(2) (West 2015) (“requiring immediate services”); MINN. STAT. § 144.344 (“[m]edical, dental, mental and other health services”); NEV. REV. STAT. § 129.030(1)(d) (“health care services”); N.Y. PUB. HEALTH LAW § 2504(4) (“[m]edical, dental, health and hospital services”); 35 PA. CONS. STAT. § 10104 (“[m]edical, dental and health services”).

240 MD. CODE ANN., HEALTH-GEN. § 20-102(b) (“medical treatment”); TENN. CODE § 63-6-222(a) (2015) (“emergency medical or surgical treatment”).

241 *See Culp & Caucci, supra* note 6, at 122.

242 In addition to the uncertainties I have raised with respect to these three dimensions, it would be critical to consider the liability dimension of emergency exceptions. Jurisdictions with narrower immunity provisions provide immunity for civil penalties that arise solely because the minor did not have capacity. *See, e.g.*, W. VA. CODE ANN. § 60A-5-504 (West 2015) (“No emergency medical service personnel may be subject to civil liability, based solely upon failure to obtain consent in rendering emergency medical services to any individual regardless of age where the patient is unable to give his or her consent for any reason.”). Jurisdictions with broader immunity provisions shelter providers from criminal and licensing body disciplinary penalties that arise solely because the minor lacked the capacity to consent. *See, e.g.*, MD. CODE ANN., HEALTH-GEN. § 20-102(e) (West 2015) (“A licensed health care practitioner who treats a minor is not liable for civil damages or subject to any criminal or disciplinary penalty solely because the minor did not have capacity to consent under this section.”). In the context of PrEP, it would be important for providers to carefully review the immunity dimension of the state’s emergency exception, with attention to case law, in light the range of potential civil claim or criminal charges that could be brought against providers who furnish PrEP pursuant to the emergency exception without parental consent. In addition to criminal liability for battery and assault, providers should consider whether their jurisdiction has a criminal statute pertaining to contributing to the delinquency of a minor and whether providers could be liable under such a statute for furnishing PrEP. Consider the following statement of immunity from regulations of the District of Columbia:

Any minor who is examined, treated, hospitalized, or receives health services under this chapter may give legal consent, and no person who administers the health services shall be liable civilly or criminally for assault, battery, or assault and battery; or any other civil legal charge, except for negligence or intentional harm in the diagnosis and treatment rendered to the minor

should first consider each of the dimensions of their state's emergency exception, determine whether the statute is broad or narrow, further review state regulations pertaining to the consent of minors in emergencies and case law interpretations of those exceptions, and examine any parental notification requirements.²⁴³ As I have indicated in the framework above, providers in states with broader emergency exceptions may have more success in furnishing care thereunder than providers in states with narrower exceptions. Additionally, lawmakers should consider amending emergency exceptions to include prophylactic treatment for exposure to STIs, which would more clearly permit prescription of PrEP without express parental consent. This furthers the public interests of securing the personal health of minors in high-prevalence groups and eliminating fear of liability that could result in delays in care. This could have secondary effects on operationalizing PrEP for self-consenting minors, as PrEP applications could lead to PrEP applications.²⁴⁴

a. State Parental Notification Laws

In addition to considering whether minors may consent to PrEP under state statutory exceptions, it is also necessary to consider whether providers are required to notify parents pursuant to state statute if a minor seeks PrEP therapy.²⁴⁵ With respect to notification in

D.C. MUN. REGS. tit. 22-B, § 602.4 (2015). In this jurisdiction, a plain reading of the regulation indicates that a provider would be immune from civil liability and certain criminal charges—specifically, assault and/or battery—for providing medical services pursuant to the emergency exception. However, by specifying assault and battery, the legislature has left open the question of whether a provider could be charged under another criminal statute.

243 See, e.g., OKLA. STAT. ANN. tit. 63, § 2602(7)(b) (West 2015) (specifying that “[t]he health professional shall be required to make a reasonable attempt to inform the . . . parent or legal guardian of the minor of any treatment needed or provided” under the emergency exception).

244 On the other hand, it is worth considering any negative effects that could result from seeking PrEP for self-consenting minors under emergency exceptions. First, because the emergency exception merely implies consent of the parent, conditioning access to PrEP on an emergency exception does not recognize the authority of minors to consent in sexual healthcare matters. Thus, it does not advance the cause of empowering youth to make decisions about protecting their own sexual health. Second, characterizing an at-risk minor's situation as an emergency requiring immediate intervention may further marginalize them and stigmatize their behavior. Relying on an emergency exception invites an inquiry into how desperate the minor's situation really is. Furnishing PrEP according to an emergency exception also invites a provider to paint the minor as having a desperate situation, which stigmatizes, even pathologizes their behavior. Thus, the goal of enabling at-risk minors to consent to pharmacological HIV prevention may be better achieved through other state and federal means.

245 Consideration of parental notification requirements in administrative and common law is beyond the scope of this Article.

connection with STI services, a 2015 survey by the Guttmacher Institute of state STI laws in United States jurisdictions (including the District of Columbia and excluding United States territories) found that no jurisdiction mandates that providers contact parents regarding STI issues.²⁴⁶ However, eighteen United States jurisdictions expressly or impliedly permit the physician to notify the parent.²⁴⁷ Statutes permitting parental notification have the potential to create inconsistent policies among providers and dissuade some youth from seeking care. The mere request for information concerning the existence of caregivers, their whereabouts, or the minor's relationship to them could make it more difficult to reach marginalized, at-risk minors.

Additionally, even though providers are not obligated to notify the parent of a minor's request for STI care, insurers regularly do notify parents of any requests. Broadly used insurance claims processing and billing practices such as explanation of benefit (EOB) paperwork transmitted to policyholders after care is provided "routinely violate confidentiality for everyone, often a minor or a young adult, insured as a dependent."²⁴⁸ One 2012 survey of state laws related to confidentiality for dependents concluded that "virtually all states requir[e] notices when claims are denied," and about fifty percent of the states "either require or presume the sending of an EOB."²⁴⁹ Because many youth would prefer to eschew sexual healthcare entirely rather than notify their parents of their intent to seek such care, addressing these breaches of confidentiality on the insurance side will be critical to operationalizing PrEP among youth, particularly if insurers begin to deny coverage requests for PrEP. One potential advocacy solution with respect to EOBs sent

246 See GUTTMACHER INST., STATE POLICIES IN BRIEF: MINORS' ACCESS TO STI SERVICES (2015), http://www.guttmacher.org/statecenter/spibs/spib_MASS.pdf [<http://perma.cc/BF88-3H82>].

247 See *id.* While no United States jurisdiction mandates parental notification about STI-related care, some jurisdictions mandate parental notification in connection with care rendered pursuant to emergency exceptions. For example, North Dakota's emergency exception requires that physicians take "reasonable steps" to notify adult caregivers before providing emergency services to minors or care to minors who are victims of sexual assault. N.D. CENT. CODE § 14-10-17.1(2) (2015). In the context of an emergency, when parental consent is implied, requiring the provider to take steps to seek express consent from an adult caregiver is logical. However, in its application to pharmacological HIV prevention, parental notification for PEP or PrEP administered to a minor pursuant to the emergency exception is problematic, as a minor who has been exposed to HIV or at risk of exposure may eschew medically necessary care if it is conditioned on parental notification. This is another reason why operationalizing pharmacological HIV prevention for minors is troublesome under emergency exceptions.

248 ABIGAIL ENGLISH ET AL., CONFIDENTIALITY FOR INDIVIDUALS INSURED AS DEPENDENTS: A REVIEW OF STATE LAWS AND POLICIES 1 (2012), <https://www.guttmacher.org/pubs/confidentiality-review.pdf> [<https://perma.cc/BB32-FV5T>].

249 *Id.*

in connection with requests for PrEP would be the development of state regulations that permit the patient to specify an address to which the insurer may send the EOB.²⁵⁰ This would permit minor patients to designate a third party, such as a youth center, to receive the EOB on their behalf. A second potential solution is a federal regulatory mandate requiring insurers to adhere to generic EOBs on parents' insurance. Such a regulation could require insurers to omit all specifics in matters involving minors and concerning sexual healthcare and addiction, generally, or STI services, specifically. This federal solution could give "teeth" to agreements between state policymakers and individual insurers that require insurers to adhere to generic EOBs.²⁵¹

Multiple barriers to confidential access to PrEP for minors—at the parental level (through parental consent requirements), the provider level (through statutes permitting parental notification), and the insurer level (through common industry practices)—stand between at-risk youth and effective HIV prevention. This is a worthy justification for permitting confidential access to PrEP in federally funded programs that ensure confidential care for minors.

b. Title X

Though there may be a number of different solutions to ensuring confidential access to pharmacological HIV prevention for at-risk minors, one potential solution to both the parental consent and parental notification dimensions is the Title X Family Planning Program.²⁵² Title X, also known as the "Population Research and Voluntary Family Planning Programs,"²⁵³ is the only grant-maker at the federal level "dedicated solely to providing individuals with comprehensive family plan and related preventive health services."²⁵⁴

250 *See generally id.* at 18 (recommending that one approach "is to send EOBs for sensitive services only to the patient using whichever address or means of communication the patient specifies").

251 In Rhode Island, for example, one state official contacted insurers directly and had insurers agree to the following: "because of [the State's] ability to test and treat STIs and HIV in adolescent populations without parental consent, the insurer must, under strict confidentiality codes, adhere to a generic EOB on the parent's insurance." E-mail from Paul Loberti, Adm'r, Exec. Office of Health & Human Servs., Medicaid Div. HIV Provision of Care, to Jason Potter Burda (Sept. 27, 2015, 15:50 EST) (on file with author).

252 This solution was suggested by Culp and Caucci, *supra* note 6, at 123.

253 Family Planning Services and Population Research Act of 1970, Pub. L. No. 91-572, 84 Stat. 1504.

254 *Title X Family Planning*, U.S. DEP'T OF HEALTH & HUM. SERVS., <http://www.hhs.gov/opa/title-x-family-planning> [<http://perma.cc/FEK2-9STK>] (last visited July 6, 2015) [hereinafter *Title X Family Planning*].

Under Title X and the regulations enforcing it,²⁵⁵ family planning clinics administered through state and local health departments, hospitals, schools, and non-profits receiving Title X funding must ensure that services are confidential.²⁵⁶ Title X clinics provide a broad range of services, including contraceptives, counseling, pregnancy testing, screening and treatment for STIs, and HIV testing.²⁵⁷ As of 2012, over 4,000 clinics across the country received Title X funds.²⁵⁸ Because all clinics must provide confidential services, receipt of services cannot be conditioned upon parental consent or notification.

If clinics receiving Title X funds offered PrEP, minors receiving such care could potentially self-consent to PrEP therapy without fear that the provider might notify his or her parents. Offering PrEP in Title X clinics also fits well with the services these clinics already offer. In 2012, Title X clinics conducted approximately 1.3 million HIV tests on men and women.²⁵⁹ Further investigation into the cost effectiveness of offering PrEP in the family planning context will be critical. In that regard, it will be important to focus on the cost savings to the government in HIV infections (and a lifetime of treatment) averted as a result of offering confidential access to PrEP on a broad scale.²⁶⁰ For clinics who decide to take Title X funds, further clarification from HHS that grant funds may be used for services related to PrEP and whether HHS would need to amend its rules and/or grant availability notices, may also be required.

Ensuring that youth have confidential access to PrEP will require holistic solutions at both the state and federal levels. While attaching PrEP to Title X clinics could make confidential PrEP therapy accessible to thousands of at-risk youth across the country who seek their healthcare through such providers, state solutions are also needed to ensure confidential PrEP access for at-risk youth who seek HIV prevention services through individual primary care physicians, advanced care nurses, state public health departments, or hospitals. To that end, the frameworks I have developed and the state-level survey herein are an excellent starting point for advocates, policymakers, and state lawmakers

255 Public Health Service Act, 42 U.S.C. § 300(a) (2012); 42 C.F.R. § 59.5(a) (2015).

256 42 U.S.C. § 300ff-61(a) (2012).

257 TITLE X FAMILY PLANNING, *supra* note 252.

258 *Id.*

259 *Id.* (citing C.I. FOWLER ET AL., RTI INT'L, FAMILY PLANNING ANNUAL REPORT: 2011 NATIONAL SUMMARY (2014)).

260 *See id.* (discussing cost savings to taxpayers in the contraception context and the additional savings from STI treatment averted through prevention efforts).

who recognize the importance of ensuring that at-risk youth have access to the most effective HIV prevention method for them without fear of parental judgment, obstruction, disownment, or violence.

III. Ensuring PrEP Acceptability Within Sexual Education

In addition to developing solutions that guarantee confidential access to PrEP for youth, advocates must also address the issue of acceptability of PrEP. Put another way, assuming that minors *can* consent to PrEP therapy without parental involvement, the next issue is whether minors will actually *want* to consent to PrEP. According to one PrEP activist, there is a perception that people who use PrEP are “very, very slutty.”²⁶¹ Ensuring PrEP acceptability among youth requires eliminating the stigma that attaches to those who use it. Doing so is best achieved through education that places PrEP alongside other long-established HIV prevention methods such as behavioral modification, risk reduction, and condoms. As I discussed in Part I, the major loci of HIV prevention education for youth are in-school sexual education programs. In this section, I explore state and federal means of ensuring that schools include accurate and complete information about PrEP in their curricula. To that end, in Part A, I develop advocacy suggestions at the local and state levels, and in Part B, I explore the potential of attaching PrEP education to grants funded by HHS’ Personal Responsibility Education Program, which touches thousands of public schools nationwide.

A. Local and State Advocacy

State statutes that require schools to include education about STIs may provide a starting point for state and local advocates seeking inclusion of PrEP information in sex education curricula. Most jurisdictions have statutes that mandate school-based instruction on STIs and HIV.²⁶² Some leave the content of instruction up to local school districts.²⁶³ As

261 Burda, *supra* note 3, at 193 (citing Mark Joseph Stern, “I Have Learned Not to Underestimate the Stigma”: Peter Staley on Truvada, Condoms, and HIV Prevention, SLATE (May 22, 2014, 9:00 AM), http://www.slate.com/blogs/outward/2014/05/22/peter_staley_talks_about_truvada_hiv_and_stigma.html [<http://perma.cc/WV69-8LKR>]).

262 See Matthew Lashof-Sullivan, *Sex Education in Schools*, 16 GEO. J. GENDER & L. 263, 264 n.1 (2015) (listing jurisdictions mandating STI instruction in public schools). A survey of state statutes pertaining to HIV education in schools is beyond the scope of this Article.

263 See, e.g., CONN. GEN. STAT. ANN., § 10-19 (b) (West 2015) (requiring inclusion of “systematic instruction on [AIDS]” but delegating “[t]he content and scheduling of the instruction” to “the local or regional board of education”).

such, advocates at the local level can play a role in encouraging individual school districts to include PrEP in HIV prevention instruction. However, other jurisdictions specify the exact requirements of programs. For example, North Carolina's statute states that each local school district must include instruction that:

[t]eaches about sexually transmitted diseases. Instruction shall include how sexually transmitted diseases are and are not transmitted, *the effectiveness and safety of all federal Food and Drug Administration (FDA)-approved methods of reducing the risk of contracting sexually transmitted diseases*, and information on local resources for testing and medical care for sexually transmitted diseases. Instruction shall include the rates of infection among pre-teen and teens of each known sexually transmitted disease and the effects of contracting each sexually transmitted disease.²⁶⁴

If, like North Carolina, a jurisdiction requires inclusion of all FDA-approved STI prevention methods, advocates working at the state level can play a role in ensuring that Truvada as PrEP, which is FDA-approved for HIV prevention, is included as a risk reduction strategy in curricula throughout the jurisdiction.²⁶⁵

Even in jurisdictions that do not mandate any STI instruction in sex education curricula, state and local advocates should play a role in encouraging state agencies and local school boards to require inclusion of information on Truvada as PrEP, specifically, or information about the existence of pharmacological HIV prevention, generally. This may be more feasible in those school districts adopting the comprehensive sex education model than in those districts adopting the abstinence-only model. To be sure, convincing schools to include education about pharmacological HIV prevention is likely easier when the school already includes a range of STI prevention methods and is not committed to the abstinence ideology.²⁶⁶

264 N.C. GEN. STAT. § 115C-81(4a)(a) (West 2015) (emphasis added).

265 Although Truvada as PrEP is only FDA-approved for use in adults eighteen years of age and older, this is not a reason to exclude it from curricula entirely, especially since some secondary school students may be eighteen years old.

266 In those communities in which schools teach abstinence as the sole means of STI prevention, local clinics and advocates play an especially important role in ensuring the dissemination of accurate information about PrEP to at-risk youth outside the school context, as these are the youth who are likely the most under-informed about HIV prevention.

Local and state advocacy related to inclusion of PrEP in sexual education curricula, however, will likely need to be supported by national advocacy on the issue, as state and local politics are notoriously contentious in matters of in-school sexual education programs.

B. National Advocacy: PrEP in PREP

In addition to seeking inclusion of PrEP in sex education curricula through state and local action, advocates may also seek inclusion of PrEP in sex education curricula through federal action. In passing the Patient Protection and Affordable Care Act on March 23, 2010,²⁶⁷ and amending Title V of the Social Security Act,²⁶⁸ Congress created the Personal Responsibility Education Program (or PREP, not to be confused with PrEP),²⁶⁹ administered by the Family and Youth Services Bureau (FYSB), a division of HHS. Through PREP, the FYSB awards grants to states to ensure youth education about “both abstinence and contraception to prevent pregnancy and sexually transmitted infections,”²⁷⁰ which includes HIV/AIDS.²⁷¹ Those states receiving PREP funding are required to provide youth with medically accurate information,²⁷² and programs must “replicate evidence-base[d] effective programs or substantially incorporate elements of effective programs.”²⁷³ Sample programs are included in funding opportunity announcements (FOAs),²⁷⁴ and future FOAs could include programs that include education on pharmacological HIV prevention methods in addition to traditional biomedical prevention methods such as condoms. However, pursuant to the Secretary’s broad discretion to ensure compliance²⁷⁵ and to mandate

267 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 42 U.S.C.).

268 *Id.* at § 2953 (amending Title V of Social Security Act).

269 42 U.S.C. § 713 (2012).

270 U.S. DEP’T OF HEALTH & HUM. SERVS., STATE PERSONAL RESPONSIBILITY EDUCATION PROGRAM FACT SHEET (2015), <http://www.acf.hhs.gov/programs/fysb/resource/prep-fact-sheet> [<http://perma.cc/5RSM-67JV>].

271 42 U.S.C. § 713(b)(2)(A)(i).

272 42 U.S.C. § 713(b)(2)(B)(i).

273 U.S. DEP’T OF HEALTH AND HUM. SERVS., STATE PERSONAL RESPONSIBILITY EDUCATION PROGRAM (PREP), ORIENTATION WEBINAR 24, 44 (Nov. 17, 2010), <http://www.acf.hhs.gov/sites/default/files/fysb/prep-webinar-slides-101117.pdf> [<http://perma.cc/ZU8J-K633>].

274 *Id.* at 24.

275 42 U.S.C. § 713(a)(4)(C) (requiring “rigorous federal evaluation” of state programs funded by the Act).

inclusion of information in grant applications not specifically required by the ACA,²⁷⁶ it is possible that the Secretary could require states to establish goals for reaching youth at risk of HIV infection. Further, to ensure the accuracy and completeness of programs, HHS could mandate or encourage inclusion of a range of HIV prevention methods in addition to condoms. This could be achieved through regulation, in FOAs, or during annual grantee meetings. This is also consistent with the Secretary's power to ensure that grantees develop programs that are "medically accurate and complete."²⁷⁷ After all, given the emergence of PrEP, a medically effective and FDA-approved HIV prevention method, comprehensive sex education programs that solely teach abstinence and condom usage as effective HIV prevention methods are incomplete.

The potential impact of this approach would be felt nationally. By way of example, in fiscal year 2010, forty-six states and the District of Columbia received federal funding for PREP sex education.²⁷⁸ Thus, targeting PREP as a means of ensuring that sex education programs include information about PrEP among the range of HIV prevention methods would guarantee that at-risk youth nationwide have a basic familiarity with PrEP, ensure its legitimacy as an effective means of HIV prevention, and help eliminate stigma surrounding it. This, in turn, could help foster substantive, honest discussions between at-risk youth and their healthcare providers about which HIV prevention method would work best for them.

CONCLUSION

Our current understanding of adolescent risk-taking and reward sensitivity makes developing strategies that shelter at-risk youth from the negative consequences of their alacrity an essential public health goal. While Truvada as PrEP is not a "magic pill" to protect against infection, it is a necessary new tool for HIV prevention among youth because of its unique, risk-shielding nature. Yet operationalizing PrEP for youth, and eventually other pharmacological HIV prevention modalities, involves compound challenges. The gravest of these challenges concerning PrEP for youth is ensuring confidential access without parental involvement. In the context of HIV-related healthcare, fear that a parent will find out about a minor's appeal for advice about protection "constitutes a significant barrier to reaching [them]."²⁷⁹ Permitting minors to access PrEP without parental involvement

276 42 U.S.C. § 713(a)(1)(C).

277 42 U.S.C. § 713(b)(2)(B)(ii).

278 Lashof-Sullivan, *supra* note 260, at 293, App. B (listing states that received federal funding for PREP).

279 *See* New York v. Schweiker, 557 F. Supp. 354, 360 (S.D.N.Y. 1983) (citing S. REP. NO. 95-102, at 26

is consistent with federal and state legislative acknowledgments of this reality in laws that lower the age of consent in matters of sexual healthcare such as STI diagnosis and treatment.

The viability of PrEP as a prevention option for at-risk youth is also dependent upon its acceptability. The addition of PrEP to school sex education curricula, achieved through state and federal action, helps make it an acceptable HIV prevention option to youth populations. If PrEP is both accessible and acceptable to at-risk youth, providers would have greater flexibility to meet the highly individual sexual healthcare needs of their adolescent patients, and youth may be more receptive to a provider's presentation of the option. Furthermore, recognizing that they have freedom of choice and armed with an understanding of the full range of HIV prevention options available, youths would also have a greater incentive to collaborate with their doctors in developing prevention regimens that work for them. This opportunity for adult-youth engagement about risk behavior means that PrEP could be a remarkable vehicle to learn about—perhaps even to shape—the adolescent mind.

One critical step toward achieving this end involves incentivizing at-risk youth to seek care by safeguarding the confidentiality of that care. Advocates, lawmakers, and policymakers should conduct reviews of minor consent and parental notification statutes using frameworks such as those herein to pinpoint: (1) any state-level opportunities to furnish PrEP without parental involvement; (2) any gaps in existing statutes that disadvantage certain at-risk youth; and (3) any justifications for federal action to help universalize confidential sexual healthcare for minors. This Article pinpoints some of these opportunities, gaps, and justifications. Achieving active engagement between adolescents and their providers also involves empowering youth to begin these conversations by giving them complete information in sex education about the full range of available HIV prevention methods. State and federal governments must take a hands-on role in guaranteeing the completeness of these programs. Knowledge gained therefrom will embolden our youth to take charge of their health, to safeguard their future, and to protect each other.

(1977), as reprinted in 1977 U.S.C.C.A.N. 549; S. REP. NO. 95-822, at 31 (1978)).

APPENDIX: STI Consent Statutes
(U.S. Jurisdictions Permitting Minors to Consent to Certain STI Services)

Table 1. Narrow: Prevention and Treatment

Jurisdiction	Citation	Relevant Text
Alaska	ALASKA STAT. § 25.20.025 (2015)	A minor may consent to “diagnosis, prevention, or treatment of pregnancy, and for diagnosis and treatment of venereal disease[.]”
Colorado	COLO. REV. STAT. § 25-4-402 (2015)	“Any physician . . . with the consent of the minor patient, may make a diagnostic examination for sexually transmitted infection and may prescribe for and treat the minor patient for sexually transmitted infection without the consent of or notification to the parent or guardian”
Connecticut	CONN. GEN. STAT. § 19a-216 (2015)	“Any municipal health department, state institution or facility, licensed physician or public or private hospital or clinic, may examine or provide treatment for venereal disease for a minor”
Florida	FLA. STAT. § 384.3 (2015)	A physician “may examine and provide treatment for sexually transmissible diseases to any minor”
Kentucky	KY. REV. STAT. ANN. § 214.185 (West 2015)	“Any physician . . . with the consent of [the] minor may advise, prescribe for, and treat such minor regarding venereal disease[.]”
Maine	ME. STAT. tit. 32, §§ 2595, 3292; ME. STAT. tit. 22, § 1823 (2015)	“An individual licensed under this chapter who renders medical care to a minor for treatment of venereal disease . . . is under no obligation to obtain the consent of the minor’s parent”
Maryland	MD. CODE ANN., HEALTH-GEN. § 20- 102(c)(3) (West 2015)	A minor has capacity to consent to “[t]reatment for or advice about venereal disease[.]”
Minnesota	MINN. STAT. § 144.343(1) (2015)	“Any minor may give effective consent for medical, mental and other health services to determine the presence of or to treat . . . venereal disease”
Mississippi	MISS. CODE ANN. § 41- 41-13 (2015)	“Any physician. . . or any nurse practitioner, who, in the exercise of due care, renders medical care to a minor for treatment of a venereal disease is under no obligation to obtain the consent of a parent or guardian”
Missouri	MO. REV. STAT. § 431.061(4) (2015)	“Any minor [may consent] for himself in case of . . . [v]enereal disease[.]”

New Hampshire	N.H. REV. STAT. ANN. § 141-C:18 (II) (2015)	“Any minor 14 years of age or older may voluntarily submit himself to medical diagnosis and treatment for a sexually transmitted disease and a licensed physician may diagnose, treat or prescribe for the treatment of a sexually transmitted disease in a minor 14 years of age or older, without the knowledge or consent of the parent or legal guardian”
New Mexico	N.M. STAT. ANN. § 24-1-9 (2015)	“Any person regardless of age has the capacity to consent to an examination and treatment by a licensed physician for any sexually transmitted disease[.]”
North Dakota	N.D. CENT. CODE § 14-10-17 (2015)	“Any person of the age of fourteen years or older may contract for and receive examination, <i>care</i> , or treatment <i>for sexually transmitted disease</i> . . . without permission, authority, or consent of a parent or guardian[.]” (emphasis added)
Ohio	OHIO REV. CODE ANN. § 3709.241 (West 2015)	“[A] minor may give consent for the diagnosis or treatment of any venereal disease by a licensed physician[.]”
Pennsylvania	35 PA. CONS. STAT § 10103 (2015)	“Any minor may give effective consent for medical and health services to determine the presence of or to treat . . . venereal disease” and other reportable diseases.
Rhode Island	23 R.I. GEN. LAWS § 23-6.3-3(1) (2015)	“[I]ndividuals under eighteen (18) years of age may give legal consent for testing, examination, and/or treatment for any reportable communicable disease, including HIV[.]”
Tennessee	TENN. CODE ANN. § 68-10-104 (2015)	“[A]ny physician may examine, diagnose and treat minors infected with STDs without the knowledge or consent of the parents of the minors”
Texas	TEX. FAM. CODE ANN. § 32.003(a)(3) (West 2015)	A minor may “consent[.] to the diagnosis and treatment of an infectious, contagious, or communicable disease”
Vermont	VT. STAT. ANN. tit. 18, § 4226 (a) (2015)	“If a minor 12 years of age or older is suspected . . . [of having] venereal disease . . . [and such is] verified by a licensed physician, the minor may give . . . his or her consent to medical treatment”
Virginia	VA. CODE ANN. § 54.1-2969(E)(1) (2015)	Consent of minor is valid for “[m]edical or health services needed to determine the presence of or to treat venereal disease[.]”
West Virginia	W. VA. CODE § 16-4-10 (2015)	“[A]ny licensed physician may examine, diagnose, or treat any minor with his or her consent for any venereal disease without the knowledge or consent of the minor’s parent or guardian[.]”
Wisconsin	WIS. STAT. § 252.11(1m) (2015)	“A physician may treat a minor infected with a sexually transmitted disease or examine and diagnose a minor for the presence of such a disease without obtaining the consent of the minor’s parents or guardian[.]”
Wyoming	WYO. STAT. ANN. § 35-4-131(a) (2015)	“Persons under eighteen (18) years of age may give legal consent for examination and treatment for any sexually transmitted disease infection[.]”

Table 2. Broader: Care or Prescription

Jurisdiction	Citation	Relevant Text
Alabama	ALA. CODE §§ 22-8-6, 22-11A-19 (2015)	“[A] minor 12 years of age or older who may have come into contact with any sexually transmitted disease as designated by the State Board of Health may give consent to the furnishing of medical care related to the diagnosis or treatment of such disease.”
Arizona	ARIZ. REV. STAT. ANN. § 44.-132.01 (2015)	“[A] minor who may have contracted a venereal disease may give consent to the furnishing of hospital or medical care related to the diagnosis or treatment of such disease”
Arkansas	ARK. CODE ANN. § 20-16-508(a)(1) (2015)	“[A] minor who believes himself or herself to have a sexually transmitted disease consents to the provision of medical care”
Georgia	GA. CODE ANN. § 31-17-7 (2015)	“The consent to the provision of medical or surgical care or services . . . when such consent is given by a minor who is or professes to be afflicted with a venereal disease, shall be as valid and binding as if the minor had achieved his majority, provided that any such treatment shall involve procedures and therapy related to conditions or illnesses arising out of the venereal disease which gave rise to the consent”
Hawaii	HAW. REV. STAT. § 577A-2 (2015)	“The consent to the provision of medical care and services . . . when executed by . . . a minor who is or professes to be afflicted with a venereal disease . . . shall be valid and binding as if the minor had achieved his or her majority”
Idaho	IDAHO CODE ANN. § 39-3801 (2015)	“[A] minor fourteen (14) years of age or older who may have come into contact with [an STI] may give consent to the furnishing of . . . care related to the diagnosis or treatment of such disease.”
Illinois	410 ILL. COMP. STAT. § 210/4 (2015)	“[A] minor 12 years of age or older who may have come into contact with any sexually transmitted disease . . . may give consent to the furnishing of medical care or counseling related to the diagnosis or treatment of the disease.”
Indiana	IND. CODE § 16-36-1-3(d) (2015)	“An individual who has, suspects that the individual has, or has been exposed to a venereal disease is competent to give consent for medical or hospital care or treatment of the individual.”
Kansas	KAN. STAT. ANN. § 65-2892 (2015)	“Any physician, upon consultation by any person under eighteen (18) years of age as a patient, may, with the consent of such person who is hereby granted the right of giving such consent, make a diagnostic examination for venereal disease and prescribe for and treat such person for venereal disease including prophylactic treatment for exposure to venereal disease whenever such person is suspected of having a venereal disease or contact with anyone having a venereal disease.”

Louisiana	LA. REV. STAT. ANN. § 40:1121.8(A) (2015)	“Consent to the provision of medical or surgical care or services by a hospital or public clinic, or to the performance of medical or surgical care or services by a physician, licensed to practice medicine in this state, when executed by a minor who is or believes himself to be afflicted with a venereal disease, shall be valid and binding as if the minor had achieved his majority. Any such consent shall not be subject to a later disaffirmance by reason of his minority.”
Massachusetts	MASS. GEN. LAWS ch. 112, § 12F(vi) (2015)	A minor can consent if “he reasonably believes himself to be suffering from or to have come in contact with any [reportable] disease . . . ; provided, however, that such minor may only consent to care which relates to the diagnosis or treatment of such disease.”
Michigan	MICH. COMP. LAWS § 333.5127(1) (2015)	“[T]he consent to the provision of medical or surgical care, treatment, or services by a hospital, clinic, or physician that is executed by a minor who is or professes to be infected with a venereal disease or HIV is valid and binding as if the minor had achieved the age of majority.”
Nebraska	NEB. REV. STAT. § 71-504 (2015)	Physician may “make or cause to be made a diagnostic examination for sexually transmitted diseases and prescribe for and treat such person for sexually transmitted diseases including prophylactic treatment for exposure to sexually transmitted diseases whenever such person is suspected of having a sexually transmitted disease or contact with anyone having a sexually transmitted disease.”
Nevada	NEV. REV. STAT. §§ 441A.310, 129.060 (2015)	“[T]he consent of the parent, parents or legal guardian of a minor is not necessary in order to authorize a local or state health officer, licensed physician or clinic to examine or treat, or both, any minor who is suspected of being infected or is found to be infected with any sexually transmitted disease.”
New Jersey	N.J. STAT. ANN. § 9:17A-4 (West 2015)	“The consent to [care], when executed by a minor who is <i>or believes that he may be</i> afflicted with a venereal disease, or who is at least 13 years of age and is <i>or believes that he may be</i> infected with [HIV] or have [AIDS] . . . shall be valid and binding . . .” (emphasis added).
New York	N.Y. PUB. HEALTH LAW § 2305(2) (McKinney 2015)	“A licensed physician, or in a hospital, a staff physician, may diagnose, treat or prescribe for a person under the age of twenty-one years without the consent or knowledge of the parents or guardian of said person, where such person is infected with a sexually transmitted disease, or has been exposed to infection with a sexually transmitted disease.”
Oregon	OR. REV. STAT. §109.610 (2015)	“[A] minor who may have come into contact with any venereal disease, including HIV, may give consent to the furnishing of hospital, medical or surgical care related to the diagnosis or treatment of such disease”

South Dakota	S.D. CODIFIED LAWS § 34-23-16 (2015)	“Any licensed physician, upon consultation by any minor as a patient, may, with the consent of such person who is hereby granted the right of giving such consent, make a diagnostic examination for venereal disease and prescribe for and treat such person for venereal disease including prophylactic treatment for exposure to venereal disease whenever such person is suspected of having a venereal disease or contact with anyone having a venereal disease. Any such consent shall not be subject to later disaffirmance by reason of minority.”
Utah	UTAH CODE ANN. § 26-6-18(1)-(3) (West 2015)	Consent to care of minor “who is or professes to be afflicted with” an STI is valid even if “professed suspicions” are unsubstantiated.
Washington	WASH. REV. CODE § 70.24.110 (2015)	“A minor fourteen years of age or older who may have come in contact with any sexually transmitted disease or suspected sexually transmitted disease may give consent to the furnishing of hospital, medical and surgical care related to the diagnosis or treatment of such disease.”

Table 3. Broadest: Adding Prevention

Jurisdiction	Citation	Relevant Text
California	CAL. FAM. CODE § 6926(a)-(b) (West 2015)	“A minor who is 12 years of age or older may consent to medical care related to the prevention of a sexually transmitted disease[.]”
Delaware	DEL. CODE ANN. tit. 13, § 710(a)-(b) (2015)	“A minor 12 years of age or over who professes to be . . . afflicted with contagious, infectious or communicable diseases . . . may give written consent, except to abortion, to any licensed physician, hospital or public clinic for any diagnostic, preventive, lawful therapeutic procedures, medical or surgical care and treatment, . . . by any physician licensed for the practice of medicine or surgery or osteopathic medicine or surgery in this State and by any hospital or public clinic, their qualified employees or agents while acting within the scope of their employment[.]”
District of Columbia	D.C. MUN. REGS. tit. 22, § B600.7 (2015)	“A minor of any age may consent to health services which he or she requests for the prevention, diagnosis, or treatment of the following medical situations: . . . A mental or emotional condition and sexually transmitted disease[.]”
Iowa	IOWA CODE § 139A.35 (2015)	“A minor shall have the legal capacity to act and give consent to provision of medical care or services to the minor for the prevention, diagnosis, or treatment of a sexually transmitted disease or infection by a hospital, clinic, or health care provider[.]”
Montana	MONT. CODE ANN. § 41-1-402(2)-(c) (2015)	“[A] minor who professes or is found to be pregnant or afflicted with any reportable communicable disease, including a sexually transmitted disease, or drug and substance abuse, including alcohol. This self-consent applies only to the prevention, diagnosis, and treatment of those conditions specified in this subsection[.]”
North Carolina	N.C. GEN. STAT. § 90-21.5(a) (2015)	“Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of . . . venereal disease and other [reportable] diseases”
Oklahoma	OKLA. STAT. tit. 63, §§ 2601, 2602 (A)(3) (2015)	“Any minor who is or has been pregnant, afflicted with any reportable communicable disease, drug and substance abuse or abusive use of alcohol; provided, however, that such self-consent only applies to the prevention, diagnosis and treatment of those conditions specified in this section [2602.]”