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The Other Pill: Expanding Access to Pre-Exposure Prophylaxis to Prevent HIV Transmission Among Minors in New York

Aaron Neishlos

Michael D'Ambrosio

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THE OTHER PILL: EXPANDING ACCESS TO PRE-EXPOSURE PROPHYLAXIS TO PREVENT HIV TRANSMISSION AMONG MINORS IN NEW YORK

*Aaron Neishlos & Michael D'Ambrosio**

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INTRODUCTION

Reproductive rights should inform the next phase in HIV prevention. Since the 1980s, medicine has made enormous strides in preventing and treating HIV infections. Today, the Food and Drug Administration (“FDA”) has approved forty different drugs to treat HIV.¹ In the last decade, AIDS-related deaths have fallen by more than thirty percent.² Still, new HIV infections predominately impact young people.³ In particular, thirteen to twenty-four year olds accounted for twenty-two percent of all new HIV-infections in 2014—a number that has not significantly declined in the last decade.⁴ To address these disparities among young people, the law should afford minors the right to access HIV-prophylactic medication.

In 2012, the FDA approved Truvada—otherwise known as Pre-Exposure Prophylaxis (“PrEP”)—to prevent HIV infections.⁵ PrEP is a once daily pill composed of two antiretroviral drugs that reduce one’s risk of HIV infection by ninety-two to ninety-nine percent.⁶ The World Health Organization (“WHO”), Centers for Disease Control and Prevention (“CDC”), and United States Public Health Service have all endorsed PrEP as an effective means to reduce the risk of HIV infection.⁷ Expanding access to PrEP among thirteen to twenty-four year olds could significantly reduce the persistent

1. See generally *Antiretroviral Drugs Used in the Treatment of HIV Infection*, U.S. FOOD & DRUG ADMIN. (Oct. 8, 2015), <http://www.fda.gov/ForPatients/Illness/HIVAIDS/Treatment/ucm118915.htm> [<https://perma.cc/VE24-LKNW>].

2. See *UNAIDS Reports a 52% Reduction in New HIV Infections Among Children and a Combined 33% Reduction Among Adults and Children Since 2001*, UNAIDS (Sept. 23, 2013), <http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2013/september/20130923prunga> [<https://perma.cc/B89N-3PXG>].

3. See *HIV Among Youth*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/hiv/group/age/youth/> [<https://perma.cc/8U5K-CPEE>].

4. See *id.*

5. See *Treatment to Prevent HIV Infection (PrEP)*, AIDS INFO NET (Oct. 22, 2016), http://aidsinfonet.org/fact_sheets/view/160 [<https://perma.cc/Y8LH-DLAZ>]; see also U.S. FOOD & DRUG ADMIN., *supra* note 1.

6. See Robert M. Grant et al., *Preexposure Chemoprophylaxis for HIV Prevention in Men Who Have Sex with Men*, 363 *NEW ENG. J. MED.* 2587, 2597 (2010).

7. See discussion *infra* Section I.C.

infection rate in this demographic—the demographic most at risk of HIV infection.⁸

In New York State, however, a minor (a person under eighteen years old) may consent to medical treatment only in unique circumstances or for specified conditions, such as mental healthcare, substance abuse treatment, or reproductive healthcare.⁹ Minors generally do not have the capacity to consent to HIV treatment.¹⁰ PrEP, however, is a prophylactic medication. It functionally resembles birth control in its daily regimen and ability to prevent the long-term health effects of sexual activity: pregnancy for birth control and HIV for PrEP.¹¹

Under New York law, a minor may pursue reproductive healthcare without parental consent.¹² Reproductive healthcare includes accessing prophylactic medication, such as the birth control pill.¹³ New York should treat PrEP as another prophylactic medication vital to reproductive health. As such, New York should recognize that, under the U.S. Constitution and New York’s Public Health Law, minors have a right to privacy that covers their right to access PrEP without parental consent. New York can imbed PrEP within the scope of reproductive healthcare through an Executive Order or Department of Health (“DOH”) regulation. If the Executive Branch refuses to act, this policy change should be pursued through litigation. Through a reproductive rights analysis to a minor’s right to access PrEP, New York can take important steps toward reducing the threat of HIV infections, ending the AIDS epidemic,¹⁴ and preserving individual autonomy in medical care.

This Article analyzes a minor’s capacity to consent to an HIV prophylactic medication, PrEP, through a reproductive rights

8. See *HIV Among Youth*, *supra* note 3.

9. See discussion *infra* Section II.B.

10. See discussion *infra* Section II.A.

11. See Grant, *supra* note 6.

12. See discussion *infra* Section III.A.

13. See discussion *infra* Section III.A. The Guttmacher Institute has identified the following as “contraceptive methods:” oral contraceptives (birth control or morning after pill), injectable, male condom, natural family planning, vaginal ring, patch, spermicide, IUD, copper IUD, hormonal IUD, diaphragm or cervical cap, and sponge. See Jennifer J. Frost et al., *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010*, GUTTMACHER INST. 31 (2012), https://www.guttmacher.org/sites/default/files/report_pdf/clinic-survey-2010.pdf [<https://perma.cc/8BVH-Q29G>].

14. See *generally Ending the AIDS Epidemic in New York State*, N.Y. ST. DEP’T OF HEALTH (Feb. 2016), https://www.health.ny.gov/diseases/aids/ending_the_epidemic/ [<https://perma.cc/VGE8-Q77N>].

framework. Part I discusses the history of HIV/AIDS as well as the medical interventions available to treat the infection. It also describes the emergence of prophylactic medication as the next stage in curbing and, potentially, ending the HIV/AIDS epidemic. Part II outlines the law governing a minor's capacity to consent to medical treatment, with a focus on HIV testing and treatment in New York State. Part III discusses the reproductive rights of minors. In particular, Part III recognizes that minors in New York have a right to access contraceptive services without parental consent. Finally, Part IV concludes that a minor's capacity to consent to contraceptive services is similar to the capacity to consent to HIV prophylactic medication. Minors, therefore, should have a reproductive right to consent to PrEP—an HIV prophylactic medication.

I. BACKGROUND: HIV/AIDS, TREATMENT, AND PREVENTION

While PrEP is a relatively new medical intervention, treatment and prevention for HIV/AIDS has been available for several decades.¹⁵ This Section examines what HIV is, who it affects, and what prevention and treatment options exist, as well as important and necessary conditions to assess how PrEP can intervene in meaningful and proactive ways.

A. What Is HIV?

HIV is the human immunodeficiency virus; infection with HIV leads to a breakdown of the immune system, making the infected person vulnerable to opportunistic infections, often resulting in acquired immune deficiency syndrome (“AIDS”).¹⁶ HIV is transmitted from an infected person to an uninfected person by exposure to blood, semen, vaginal secretions, or breast milk.¹⁷ For transmission to occur, fluid must come in contact with a mucous membrane or damaged tissue or be directly injected into the bloodstream.¹⁸ In the United States, HIV is most commonly transmitted by anal or vaginal sex or by sharing needles with an

15. *See generally History of HIV/AIDS Overview*, AVERT, <http://www.avert.org/professionals/history-hiv-aids/overview> [<https://perma.cc/MDN2-H5R8>].

16. *See HIV Basics*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 6, 2015), <http://www.cdc.gov/hiv/basics/> [<https://perma.cc/QQ4L-MUWB>]. *See also infra* notes 20-21.

17. *See HIV Transmission*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 14, 2015), <http://www.cdc.gov/hiv/basics/transmission.html> [<https://perma.cc/S7PZ-BD8X>].

18. *See id.*

infected person.¹⁹ The risk of transmission varies, depending on the type of exposure; however, adherence to post-infection medication and treatment can reduce the risk of further transmission by as much as ninety-six percent.²⁰

HIV causes damage by destroying blood cells that help the body fight diseases, known as CD4+ or T cells.²¹ Some people develop short-term symptoms within weeks of being infected with HIV, but more often people do not experience significant symptoms for several years.²² As the HIV virus spreads throughout the body, it destroys CD4+ cells, which weakens the body's immune system.²³ Failure to obtain early treatment for HIV may exacerbate underlying health conditions, such as cardiovascular disease, kidney disease, liver disease, and cancer.²⁴ AIDS typically occurs in the late-stage of an HIV infection²⁵ when an infected individual's immune system is severely damaged and unable to fight certain diseases and cancers.²⁶ Individuals with HIV/AIDS also face increased vulnerability to certain categories of illnesses that attack weakened immune systems.²⁷ These illnesses, together known as "opportunistic infections," include tuberculosis, bacterial pneumonia, septicemia, and lymphoma among others.²⁸

19. *See id.*

20. *See HIV Risk Behaviors*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 16, 2015), <http://www.cdc.gov/hiv/risk/estimates/riskbehaviors.html> [<https://perma.cc/A44V-83VE>]. For example, exposure to HIV during a blood transfusion carries a much higher risk of transmission than other exposures, such as oral sex.

21. *See About HIV/AIDS*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 6, 2015), <http://www.cdc.gov/hiv/basics/whatishiv.html> [<https://perma.cc/E3R7-97EY>].

22. *See id.*

23. *See id.*; *HIV Basics*, *supra* note 16.

24. *See About HIV/AIDS*, *supra* note 21.

25. *See id.*

26. *See id.*

27. *See HIV Related Opportunistic Infection: Prevention and Treatment*, AVERT (May 1, 2015), <http://www.avert.org/hiv-opportunistic-infections.htm> [<https://perma.cc/SCX9-M2EW>].

28. *See id.* The stage to which the disease has progressed often dictates which of these infections presents in an individual. For instance, individuals with HIV experience higher rates of tuberculosis, malaria, bacterial pneumonia, herpes zoster, staphylococcal skin infections and septicemia, while individuals with advanced HIV or AIDS are more vulnerable to infections such as pneumocystus pneumonia, toxoplasmosis and cryptococcosis. *See id.*

B. The Demographics of HIV

There are more than 1.2 million people in the United States living with HIV.²⁹ As of 2013, approximately 129,000 people in New York State were living with HIV or AIDS,³⁰ nearly eighty percent of whom live in New York City.³¹ In 2013, 3800 new individuals were diagnosed with HIV in New York State,³² 2832 of whom lived in New York City.³³ In 2014, the number of newly diagnosed individuals in New York City dropped slightly to 2718.³⁴ The New York City Department of Health and Mental Hygiene (“DOHMH”) estimates that one in five HIV-positive people do not know their status.³⁵

Historically, gay, bisexual, and other men who have sex with men (“MSM”) have been the individuals predominantly affected by HIV/AIDS.³⁶ This trend continues in New York State, with MSM comprising approximately seventy-one percent of new HIV infections in 2013.³⁷ The plurality of these new MSM infections occurred in people aged twenty-five to thirty-four (thirty-three percent or an estimated 966 infections), while thirteen to twenty-four year olds accounted for twenty-three percent of new infections.³⁸ Thus, fifty-six percent of new infections occur in those thirteen to thirty-four years old. Although most age groups have seen a decline in new HIV infections since 2006, the infection rate for thirteen to twenty-four year olds has persisted, with the number of new infections in 2013 only slightly less than in 2006.³⁹

29. See *HIV in the United States: At a Glance*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 29, 2015), <http://www.cdc.gov/hiv/statistics/overview/ata-glance.html> [<https://perma.cc/W3E9-4AEJ>].

30. See *HIV/AIDS: An Evolving Epidemic*, N.Y.C. AIDS MEM’L (Jan. 2013), <http://nycaidsmemorial.org/resources/> [<https://perma.cc/W2UE-SUV9>].

31. See *id.*

32. See *New York–2015 State Health Profile*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 2015), http://www.cdc.gov/nchstp/stateprofiles/pdf/new_york_profile.pdf [<https://perma.cc/8P9T-398L>].

33. See *HIV Surveillance Annual Report, 2014*, N.Y.C. DEP’T OF HEALTH & MENTAL HYGIENE (Dec. 2015), <https://www1.nyc.gov/assets/doh/downloads/pdf/dires/2014-hiv-surveillance-annual-report.pdf> [<https://perma.cc/Z46H-5YXX>].

34. See *id.*

35. See N.Y.C. AIDS MEM’L, *supra* note 30.

36. See *HIV in the United States: At a Glance*, *supra* note 29.

37. See *HIV Incidence Estimates for New York State 2013*, N.Y. ST. DEP’T OF HEALTH (Dec. 2015), http://www.health.ny.gov/diseases/aids/general/statistics/docs/hiv_incidence_2013.pdf [<https://perma.cc/5NA2-TVFY>].

38. See *id.*

39. See *id.*

It should be noted that HIV infection disproportionately affects racial minorities.⁴⁰ In 2013, African Americans and Latinos made up only thirty-two percent of New York State's population, but almost seventy percent of estimated new HIV infections.⁴¹ At the end of 2012, there were approximately 496,500 African Americans living with HIV in the U.S., forty-one percent of all Americans living with the virus.⁴² In 2013, African Americans constituted fifty-four percent of total deaths attributed to HIV/AIDS.⁴³ The estimated HIV infection rate for African Americans was six times higher than that of whites, and the rate for Latinos was five times higher.⁴⁴ Nationally, the racial infection rate disparity is even greater. African American and Latino MSM account for eighty percent of new infections of MSM under the age of twenty-five, even though they typically engage in less risky behavior than white MSM.⁴⁵

C. HIV Treatment

In contrast to the first fifteen years of the HIV/AIDS epidemic, there are now numerous treatment options available that suppress the virus, allowing individuals to live symptom-free for longer periods.⁴⁶ Combining these medications, referred to as HAART (Highly Active Antiretroviral Therapy),⁴⁷ limits or slows down the destruction of the immune system and the development of AIDS, improves health, and

40. *See id.*

41. *See id.*

42. *See HIV Among African Americans*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 4, 2016), <http://www.cdc.gov/hiv/group/raciaethnic/african-americans/> [<https://perma.cc/L6FV-4F7T>]. African Americans, however, only comprise twelve percent of the U.S. population.

43. *See id.*

44. *See* N.Y. ST. DEP'T OF HEALTH, *supra* note 37.

45. Donald G. McNeil Jr., *Poor Black and Hispanic Men Are the Face of H.I.V.*, N.Y. TIMES (Dec. 4, 2013), <http://www.nytimes.com/2013/12/05/us/poor-black-and-hispanic-men-are-face-of-hiv.html> [<https://perma.cc/JS5R-776K>]. While young Black MSM have been shown to take fewer risks than their white peers (i.e., they had fewer partners, engaged in fewer acts of sex while under the influence, and used condoms more often), other risk factors, such as a lack of health insurance and the fact that more of their partners were older black men (who are more likely to have untreated HIV than older white men), may contribute to an explanation for this monumental spike.

46. *HIV/AIDS*, NAT'L INST. OF ALLERGY & INFECTIOUS DISEASES, <http://www.niaid.nih.gov/topics/hivaids/understanding/treatment/pages/default.aspx> [<https://perma.cc/UF7X-KW8F>].

47. Marcie F. Rubin et al., *Examination of Inequalities in HIV/AIDS Mortality in the United States from a Fundamental Cause Perspective*, 100 AM. J. PUB. HEALTH 1053 (2009) (defining HAART and explaining its effects on mortality).

reduces the potential for transmitting the virus to others.⁴⁸ Although these treatments have transformed HIV/AIDS into more of a chronic condition than the death sentence it once was, there remains no cure for HIV or AIDS. In 2013 an estimated 12,963 people died from HIV in the United States.⁴⁹

The FDA has approved forty antiretroviral drugs (“ARVs”) for HIV treatment.⁵⁰ ARVs are organized into six major drug classes and each group attacks HIV in a different manner.⁵¹ Medical practitioners generally recommend that HIV-positive persons take two or more ARVs from different groups at a time.⁵² Combining ARVs significantly reduces the rate at which HIV becomes resistant to the drugs, improving their efficacy.⁵³

Although the “cocktail” of available treatments is a vast improvement over previous medications, modern medications still present difficulties, including potential side effects and unknown harms that arise from long-term use.⁵⁴ In light of the relative uncertainty regarding the possible harms of long-term treatment, medical experts only recently concluded that the benefits of starting

48. *See About HIV/AIDS*, *supra* note 21.

49. *See HIV in the United States: At a Glance*, *supra* note 29.

50. *See* U.S. FOOD & DRUG ADMIN., *supra* note 1.

51. *Types of HIV/AIDS Antiretroviral Drugs*, NAT’L INST. OF ALLERGY & INFECTIOUS DISEASES, <https://www.niaid.nih.gov/diseases-conditions/types-hiv-aids-antiretroviral-drugs> [<https://perma.cc/B7Q5-3QZF>] (last updated Sept. 23, 2013) (explaining that the classes are entry inhibitors, fusion inhibitors, reverse transcriptase inhibitors, integrase inhibitors, protease inhibitors, and multi-class combination products; each class of drug attempts to interfere or interrupt the virus cells from replicating or entering a patient’s own cells at a specific point during the virus’ reproduction cycle).

52. *Id.* This approach is called “HAART.” *See* Rubin, *supra* note 47, at 1053.

53. *Drug Resistance*, AIDS.GOV, <https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/treatment-options/drug-resistance/> [<https://perma.cc/X2V9-JQGN>] (last updated Apr. 20, 2016).

54. *Long-Term Side Effects*, AIDS.GOV, <https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/treatment-options/side-effects/> [<https://perma.cc/94PJ-RDT4>] (last updated Aug. 7, 2009) (listing “Anemia (abnormality in red blood cells), Diarrhea, Dizziness, Fatigue, Headaches, Nausea and vomiting, Pain and nerve problems, Rash” as some of the short-term side effects of ARV treatments; also listing lipodystrophy (a problem in the way the body uses and stores fat), insulin resistance, lipid abnormalities, decrease in bone density, and lactic acidosis (a buildup of cellular waste in the body)); *see also* David France, *Another Kind of AIDS Crisis*, N.Y. MAG. (Nov. 1, 2009), <http://nymag.com/health/features/61740/> [<https://perma.cc/7UJE-VQ9Y>] (stating that “A striking number of HIV patients are living longer but getting older faster—showing early signs of dementia and bone weakness usually seen in the elderly.”).

treatment early outweigh the risks.⁵⁵ However, long-term health concerns still exist.⁵⁶ Beyond health concerns, there are also practical and theoretical matters to consider. HIV treatment is complicated, intensive, and costly.⁵⁷ Though treatment has become less burdensome and more effective over time, treatment regimens still generally require taking various types of medication concurrently.⁵⁸ Medications often have specific timing and dietary restrictions, with which adherence is paramount.⁵⁹ The strictures of treatment may be especially daunting for an adolescent patient who must manage medical appointments and treatment administration along with other life demands. If an adolescent patient forgoes or avoids certain components of treatment, the overall benefit of treatment may prove ineffective.

Although there is potential for harm and the treatment regimens are complex, treatment offers clear benefits, significantly reducing morbidity and mortality regardless of age, race, sex, or method of transmission.⁶⁰ Moreover, treatment can reduce the risk of viral transmission through sexual activity by up to ninety-six percent, a significant public health consideration in the initiation of ARV treatment.⁶¹ This discovery of reduced transmission rates has the

55. See Maggie Fox, *Early Treatment Best for HIV*, NBC NEWS (May 27, 2015), <http://www.nbcnews.com/health/health-news/early-treatment-best-hiv-study-confirms-n365461> [<https://perma.cc/TBN2-XRN5>].

56. See Sean Cahill & Robert Valadéz, *Growing Older with HIV/AIDS*, 103 AM. J. PUB. HEALTH e7 (2013) (“More research is needed to sort out the causality of HIV/AIDS and HIV treatments in comorbidities, and the interactions of antiretrovirals and other medications.”).

57. *HIV Cost-Effectiveness*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/hiv/prevention/ongoing/costeffectiveness/> [<https://perma.cc/9SCH-RVM6>] (last updated Sept. 23, 2013) (estimating the lifetime treatment cost of an HIV infection at \$379,668 in 2010 dollars). By contrast, HIV testing is noninvasive and occurs quickly. See *HIV Counseling & Testing Resource Directory*, N.Y. ST. DEP’T OF HEALTH, http://www.health.ny.gov/diseases/aids/providers/testing/docs/testing_toolkit.pdf [<https://perma.cc/B58T-3U23>] (last updated June 2015).

58. *HIV and Its Treatment*, AIDS INFO, <https://aidsinfo.nih.gov/education-materials/fact-sheets/21/51/hiv-treatment—the-basics#> [<https://perma.cc/FCF7-NHB4>] (last updated Sept. 13 2016). However, more than one drug can be combined into the same pill.

59. See *generally Your Diet and Anti-HIV Drugs*, AIDSMAP (Aug. 2016), <http://www.aidsmap.com/Your-diet-and-anti-HIV-drugs/page/2029328/> [<https://perma.cc/K4SN-HJL2>].

60. Palella, F. et al., *Declining Morbidity and Mortality Among Patients with Advanced Human Immunodeficiency Virus Infection*, 338 NEW ENG. J. MED. 853 (Mar. 26, 1998), <http://www.nejm.org/doi/full/10.1056/NEJM199803263381301> [<https://perma.cc/PU3M-MCQS>].

61. Myron S. Cohen et al., *Prevention of HIV-1 Infection With Early Antiretroviral Therapy*, 365 NEW ENG. J. MED. 493, 503 (2011).

potential to significantly change the focus of HIV treatment and prevention.

The use of ARV treatment for children and adolescents presents some unique concerns. The market for pediatric ARV drugs is small and there are few children to participate in clinical trials;⁶² as such, most adult-approved drugs lack an FDA pediatric label indication.⁶³ Thus, physicians often prescribe ARV treatment to minors without always knowing the effective dosing.⁶⁴ The federal Department of Health and Human Services (“HHS”) cautions physicians to consult with pediatric HIV specialists to identify patient and drug-specific concerns and to investigate the availability of any clinical data on each drug’s use in minors.⁶⁵

D. PrEP

In 2014, the CDC issued guidelines endorsing a new mode of HIV prevention.⁶⁶ PrEP is a daily drug regimen, utilized as a prevention strategy by individuals who do not have HIV, but who engage in behavior that puts them at a higher risk of contracting it.⁶⁷ PrEP currently consists of one tablet of Truvada, a combination of two HIV medications: tenofovir and emtricitabine.⁶⁸ No health organization

62. *Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection*, AIDSINFO, DEP’T OF HEALTH & HUM. SERVS., <https://aidsinfo.nih.gov/guidelines/html/2/pediatric-arv-guidelines/107/the-use-of-antiretroviral-agents-not-approved-for-use-in-children> [<https://perma.cc/8H74-HZHC>] (last updated Nov. 1, 2012). Importantly, however, the use of ARV treatment by pregnant women living with HIV can reduce the risk of HIV transmission to the child to below five percent (whereas without treatment, the risk of transmission is between fifteen and forty-five percent). See *Prevention of Mother-to-Child Transmission (PMTCT) of HIV*, AVERT, <http://www.avert.org/professionals/hiv-programming/prevention/prevention-mother-child> [<https://perma.cc/QBS8-N29Y>] (last updated Oct. 5, 2016).

63. See AIDSINFO, *supra* note 62.

64. See *id.*

65. See *id.*

66. See *generally Preexposure Prophylaxis for the Prevention of HIV Infection in the U.S.*, CTRS. FOR DISEASE CONTROL & PREVENTION (2014), <http://www.cdc.gov/hiv/pdf/prepguidelines2014.pdf> [<https://perma.cc/XC8U-9USC>].

67. *Pre-Exposure Prophylaxis (PrEP)*, AIDS.GOV, <https://www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/pre-exposure-prophylaxis/> [<https://perma.cc/6QUH-VHYA>] (last updated Jan. 29, 2016).

68. *Id.*; see also *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*, DEP’T OF HEALTH & HUM. SERVS., <https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf> [<https://perma.cc/24AR-PKAL>] (last updated July 14, 2016).

recommends any other drug for the purposes of PrEP.⁶⁹ The FDA approved Truvada as PrEP for public consumption on July 16, 2012.⁷⁰

Clinical studies have demonstrated that PrEP is highly effective at reducing the risk of HIV transmission. A 2010 study (“the iPrEx study”) compared Truvada with a placebo pill in nearly 2500 subjects, consisting of MSM and transwomen in six countries.⁷¹ The study demonstrated that for individuals with detectable levels of the drugs in their blood (i.e., indicating that the medication was being taken regularly), HIV transmission rates dropped by ninety-two percent.⁷² Further analyses indicated that daily adherence to PrEP may reduce an individual’s likelihood of contracting HIV by ninety-nine percent.⁷³ In a study consisting of men and women in serodiscordant couples, couples in which one partner had HIV but the other did not,⁷⁴ PrEP reduced the risk of HIV transmission by up to ninety

69. *PrEP 101*, BIRMINGHAM AIDS OUTREACH, <http://www.birminghamaidsoutreach.org/#!prep/c241g> [<https://perma.cc/N3CU-ZUFM>] (“Although other HIV drugs are currently being studied, no other pill besides Truvada . . . has been shown to prevent HIV infection. Therefore, you should not use any other HIV pill in place of Truvada.”).

70. *FDA approves first drug for reducing the risk of sexually acquired HIV infection*, U.S. FOOD & DRUG ADMIN. (July 16, 2012), <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm312210.htm> [<https://perma.cc/PQG5-S2CA>].

71. *See Grant*, *supra* note 6, at 2587-99 (studying Peru, Ecuador, South Africa, Brazil, Thailand, and the United States).

72. *See id.*; *see also* AIDS INFONET, *supra* note 5 (noting that research showed over ninety percent reduction in HIV infections when PrEP was taken four times a week).

73. *See* AIDS INFONET, *supra* note 5. In a recent study, 100% of the participants remained HIV-free during the 2.5 years of observation. The study was the first to show results from a “demonstration project,” which examines medication use outside the rigid confines of a placebo-controlled randomized controlled trial. This makes its findings a somewhat better prediction of PrEP’s effects in a real-world setting. *See* Jonathan E. Volk et al., *No New HIV Infections with Increasing Use of HIV Preexposure Prophylaxis in a Clinic Practice Setting*, CLINICAL INFECTIOUS DISEASES 61, 1601-03 (2015); *see also* Benjamin Ryan, *100% Efficacy for Gays Who Adhered in PrEP Study; Most Didn’t*, POZ (July 22, 2014), <https://www.poz.com/article/iPrEx-OLE-results-25922-2484> [<https://perma.cc/2PHG-47VT>]. However, in early 2016, one patient, who used PrEP as directed, became infected with HIV, showing that while Truvada may be especially effective, it does not eliminate the risk of contracting HIV. *See* Trenton Straube, *Meet the Man Who Got HIV While on Daily PrEP*, POZ (Mar. 3, 2016), <https://www.poz.com/article/meet-man-got-hiv-daily-prep> [<https://perma.cc/9QQ3-UC2C>].

74. A “serodiscordant” relationship is one in which one partner is HIV-positive and the other is HIV-negative. *See* Raymond A. Smith, “*Couples*,” BODY (1998), <http://www.thebody.com/content/art14009.html> [<https://perma.cc/U35Z-F8YJ>].

percent.⁷⁵ Among injection drug users, a daily tablet containing only tenofovir reduced the risk of contracting HIV by nearly forty-nine percent; for study participants who had detectable tenofovir in their blood (i.e., regular use of the medication), it reduced the risk of infection by seventy-four percent.⁷⁶ Despite its efficacy, PrEP is intended for use with condoms and clean needles, so that each method can compensate for the deficits of the other.⁷⁷ PrEP has no reported major side effects, and minor side effects, such as nausea, subside over time.⁷⁸

Although Truvada was approved by the FDA for prevention purposes in 2012, the CDC only amended its guidelines in May 2014.⁷⁹ The guidelines recommend that individuals who are at “high risk” for contracting HIV from sex or injection drug use consider using PrEP to mitigate the risk of contracting the virus.⁸⁰ Those at “high risk” include any HIV-negative individual in an ongoing sexual relationship with an HIV-positive partner; any HIV-negative gay or bisexual man not in a mutually monogamous relationship who has

75. Jared M. Baeten et al., *Antiretroviral Prophylaxis for HIV-1 Prevention Among Heterosexual Men and Women*, 367 NEW ENG. J. MED. 399, 405 (2012), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3770474/> [<https://perma.cc/TP8M-SE3F>].

76. Kachit Choopanya, *Antiretroviral Prophylaxis for HIV Infection in Injecting Drug Users in Bangkok, Thailand*, 381 LANCET 2083, 2088 (2013).

77. See *HIV/AIDS: Pre-Exposure Prophylaxis (PrEP)*, CTNS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/hiv/risk/prep/index.html> [<https://perma.cc/B8N7-MUZC>] (last updated Sept. 19, 2016); see also *Truvada: Important Safety Information*, GILEAD (2016), <https://start.truvada.com/hcp/important-safety-information#> [<https://perma.cc/JG6E-Q89L>]. A 2015 study demonstrated that MSM who always use condoms and who adhere to the daily regimen of Truvada at a rate of at least ninety percent have an estimated ninety-two percent lower HIV risk than those who never use condoms or PrEP. In contrast, MSMs who only use condoms have a seventy percent lower risk of an HIV infection. See Benjamin Ryan, *How Well Do Condoms and PrEP Prevent HIV Among Gay and Bi Men?*, POZ (Feb. 4, 2015), <https://www.poz.com/article/condom-PrEP-efficacy-26766-8889> [<https://perma.cc/9PBN-BTLY>].

78. *HIV/AIDS: PrEP*, CTNS. FOR DISEASE CONTROL & PREVENTION (Dec. 14, 2015), <http://www.cdc.gov/hiv/basics/prep.html> [<https://perma.cc/J3Q4-F3JY>]; see also Mark Joseph Stern, *There Is a Daily Pill That Prevents HIV. Gay Men Should Take It*, SLATE (Jan. 6, 2014), http://www.slate.com/blogs/outward/2014/01/06/truvada_prep_hiv_gay_men_should_take_pre_exposure_prophylaxis.html [<https://perma.cc/2DT9-23KX>] (stating that “Truvada has virtually no side effects”); but see France, *supra* note 54 (outlining possible harms with long-term treatment).

79. See *Preexposure Prophylaxis for the Prevention of HIV Infection in the U.S.*, *supra* note 66. As discussed, Truvada was an existing ARV drug, suitable for use as treatment after infection, before being approved for PrEP. See DEP’T OF HEALTH & HUM. SERVS., *supra* note 68.

80. See *generally Preexposure Prophylaxis for the Prevention of HIV Infection in the U.S.*, *supra* note 66, at 12.

had anal sex without using a condom or has been diagnosed with a sexually transmitted disease in the six months preceding PrEP treatment; or any HIV-negative heterosexual man or woman who does not regularly use condoms during sex with partners of unknown HIV status.⁸¹ The CDC also recommends PrEP for HIV-negative individuals who have injected drugs in the six months preceding PrEP treatment and who have shared needles or been in drug treatment during those same six months.⁸²

A federal interagency working group led by the CDC developed the 2014 Clinical Practice Guidelines; they reflect input from stakeholders across the care spectrum, including providers, people living with HIV, partners, and other affected communities.⁸³ The guidelines discuss whether PrEP is safe and effective for adolescents, but conclude that current data is insufficient.⁸⁴ The guidelines recommend that states consider the benefits and risks of adolescent use of PrEP in the context of local laws about autonomy in health care decision-making by minors.⁸⁵ However, while noting that past HIV prevention methods have not been adequately successful, the guidelines suggest that additional HIV prevention tools are necessary to reduce the rate of new infections, “especially (but not exclusively) among young adult and adolescent MSM of all races and Hispanic/Latino ethnicity and for African American heterosexuals”⁸⁶ Importantly, the guidelines note that while parental or guardian involvement often may be desirable when considering an adolescent minor’s use of PrEP, it may sometimes be adverse to the safety of the adolescent.⁸⁷

Since its introduction, PrEP has gained a lot of focus and attention, both supporting and opposing its use. In July 2014, the WHO issued guidelines strongly recommending MSM to consider taking PrEP as a

81. *See id.*

82. *See id.* at 30.

83. *Guidelines and Recommendations*, CTRS. FOR DISEASE CONTROL & PREVENTION (Aug. 23, 2016), <http://www.cdc.gov/hiv/guidelines/index.html> [<https://perma.cc/5L6T-LE6Z>].

84. *See Preexposure Prophylaxis for the Prevention of HIV Infection in the U.S.*, *supra* note 66, at 9, 43.

85. *See id.* at 42-43.

86. *See id.* at 13; *see also* McNeil, *supra* note 45 (explaining higher seroprevalence and infection rates for young men of color).

87. *Preexposure Prophylaxis for the Prevention of HIV Infection in the U.S.*, *supra* note 66, at 42; *see also* discussion *infra* Section III.A.

method of preventing HIV infection.⁸⁸ New York Governor Andrew Cuomo, as a part of his pledge to end the HIV/AIDS epidemic in the state by 2020, is committed to providing access to PrEP to high-risk HIV-negative individuals to keep them from becoming infected with HIV.⁸⁹ Governor Cuomo has launched the PrEP Assistance Plan (“PrEP-AP”), which reimburses service providers who treat eligible individuals engaging in high-risk activity and seeking primary medical care from experts in HIV prevention.⁹⁰ PrEP-AP further ensures that such individuals, if uninsured, receive PrEP through a manufacturer-patient assistance program.⁹¹

In his endorsement of PrEP, Governor Cuomo stated that “expanding PrEP assistance is a critically important step toward eradicating the AIDS epidemic in [New York] state.”⁹² His plan recognizes that while New York has made strides in reducing HIV infections for some individuals engaging in high-risk behavior, including injection drug users, progress in reducing infection among MSM, and particularly young MSM, has been slow.⁹³ Medical experts and advocates for persons with HIV have also endorsed the use of PrEP as a safe and effective HIV prevention tool.⁹⁴

PrEP, however, suffers from an image problem. PrEP’s most vehement opponents come from within the HIV/AIDS activist community.⁹⁵ Many are concerned that once on PrEP, gay men will

88. Melissa Hellmann, *WHO Says All Men Who Have Sex With Men Should Take Antiretroviral Drugs*, TIME (July 11, 2014), <http://time.com/2975573/who-hiv-aids-gay-men-homosexual-epidemic-rise/> [<https://perma.cc/23LW-J2UM>].

89. *Pre-Exposure Prophylaxis Assistance Program (PrEP-AP)*, N.Y. ST. DEP’T OF HEALTH, <https://www.health.ny.gov/diseases/aids/general/resources/adap/prep.htm> [<https://perma.cc/749Z-X7WP>].

90. *Id.*

91. *Id.*

92. *Governor Cuomo Announces Program to Protect High-Risk Individuals from HIV*, PRESS OFF. OF GOVERNOR ANDREW CUOMO (May 12, 2015), <https://www.governor.ny.gov/news/governor-cuomo-announces-program-protect-high-risk-individuals-hiv> [<https://perma.cc/WAN4-FP3Z>].

93. Daniel Costa-Roberts, *8 Things You Didn’t Know About Truvada*, PBS NEWSHOUR (Apr. 12, 2015), <http://www.pbs.org/newshour/rundown/8-things-didnt-know-truvadaprep/> [<https://perma.cc/W5VL-PDMN>].

94. *See, e.g.*, Stern, *supra* note 78 (“Basically Truvada is a miracle drug.”); *see also* Alice Park, *There’s a Drug That Prevents HIV. Let’s Use It*, TIME (Nov. 16, 2015), <http://time.com/4114402/aids-hiv-drug-prep/> [<https://perma.cc/P7CF-J6LR>] (“And it’s time for more cities and states to take San Francisco’s lead and figure out ways to make PrEP available to those who can benefit most.”).

95. Stern, *supra* note 78; *see generally* Tom Myers, *HIV Prevention Pill Will Do More Harm Than Good*, U.S. NEWS (Aug. 3, 2012), <http://www.usnews.com/opinion/articles/2012/08/03/hiv-prevention-pill-will-do-more-harm-than-good-hiv-pill-will-give-a-false-sense-of-security> [<https://perma.cc/S3RA-6T98>] (Myers, the author,

stop using other precautions to reduce the transmission of HIV.⁹⁶ In fact, before the FDA approved Truvada, the AIDS Healthcare Foundation lobbied the agency to reject the drug for use as PrEP.⁹⁷ Regan Hofmann, the former editor-in-chief of *Poz* magazine has derided PrEP as a “profit-driven sex toy for rich Westerners,”⁹⁸ while Dan Savage, a nationally syndicated sex columnist, has described PrEP-users as “self-identified idiots who can only be saved by a vaccine.”⁹⁹ Critics have also expressed concern that HIV strains may become resistant to PrEP, as well as the physiological harm that may result from long-term use of Truvada.¹⁰⁰

Several studies have demonstrated, however, that PrEP use does not lead to “sexual risk compensation” (i.e., opting out of other safe sex practices).¹⁰¹ Nonetheless, PrEP’s opponents have denigrated individuals who have taken advantage of the medication, labeling them “Truvada whores”¹⁰²—individuals who take the drug to excuse or justify their unsafe sexual behavior.¹⁰³ PrEP’s advocates have since reappropriated the term and have recast PrEP as “a drug that represents the possibility of sexual autonomy and an opportunity to push against the normative model” of heterosocialized queer life.¹⁰⁴

is the chief of public affairs and general counsel for the AIDS Healthcare Foundation).

96. Myers, *supra* note 95.

97. *Id.* The AIDS Healthcare Foundation is a Los Angeles-based non-profit organization that provides medicine and advocacy to people with HIV/AIDS. It is the largest provider of HIV/AIDS medical care in the United States. See AIDS HEALTHCARE FOUND., <http://www.aidshealth.org/#/about> [https://perma.cc/99EX-7XRS].

98. See Christopher Glazek, *Why Is No One On the First Treatment to Prevent H.I.V.?*, NEW YORKER (Sept. 30, 2013), <http://www.newyorker.com/tech/elements/why-is-no-one-on-the-first-treatment-to-prevent-h-i-v> [https://perma.cc/4WWY-SC9E].

99. Richard Morgan, *Sex and the H.I.V. Morning-After Pill*, N.Y. TIMES (June 28, 2013), <http://www.nytimes.com/2013/06/29/opinion/sex-and-the-hiv-morning-after-pill.html> [https://perma.cc/2N7Y-F2BS].

100. See Myers, *supra* note 95.

101. See, e.g., *Study Shows PrEP Does Not Lead to Increases in Risky Sex Among Gay Men*, CTR. FOR HIV IDENTIFICATION PREVENTION & TREATMENT SERVS. (Sept. 2013), <http://chipts.ucla.edu/study-shows-prep-does-not-lead-to-increases-in-risky-sex-among-gay-men/> [https://perma.cc/756S-PZL5].

102. See Park, *supra* note 94.

103. See Jim Burrell, *‘Truvada Whores’ Stigma Endures Among Doctors and LGBTs*, ADVOCATE (Aug. 11, 2014), <http://www.advocate.com/health/2014/08/11/truvada-whore-stigma-endures-among-doctors-and-lgbts> [https://perma.cc/Z7TN-RN55].

104. See Aaron Braun, *‘Truvada Whores’ and the Class Divide*, PACIFIC STANDARD (Aug. 17, 2015), <http://www.psmag.com/health-and-behavior/truvada-whores-and-the-aids-class-divide> [https://perma.cc/7YED-X7VJ]. Though the author does not use that term, by “heterosocialized queer life,” we refer to the experience of

The social critics of PrEP raise valid concerns. Although PrEP represents the next stage in the scientific study and medical treatment of HIV/AIDS, science and medicine must coincide with social norms and legal rules. The next Part of this Article addresses the legal rules governing an individual's access to PrEP.

II. ASSESSING THE CURRENT LEGAL LANDSCAPE

This Part outlines the laws governing a minor's capacity to consent to medical treatment, focusing on the capacity to consent to HIV testing and treatment. In special circumstances a minor may be able to consent to HIV testing and treatment, notwithstanding the typical requirement of parental consent.

A. Informed Consent

Over a hundred years ago, writing for the New York Court of Appeals in *Schloendorff v. Society of New York Hospital*, then-Judge Benjamin Cardozo stated, “[e]very human being of adult years and sound mind has a right to determine what shall be done with his body”¹⁰⁵ Throughout the past century, U.S. courts have uniformly held that self-determination and individual autonomy are the principles underlying the legal doctrine of informed consent—that is, freedom from non-consensual interference with one's person.¹⁰⁶

Informed consent imposes two duties on medical providers: (1) the duty to disclose information and (2) the duty to obtain informed consent from the patient.¹⁰⁷ The provider must disclose alternative treatments as well as “reasonably foreseeable risks and benefits involved as a reasonable medical, dental or podiatric practitioner

being a queer or LGBT-identified person in a world where heterosexuality is the normal or preferred sexual orientation, and where, at least implicitly, queer or LGBT-identified individuals are pressured to assimilate into such a model of existence.

105. 211 N.Y. 125, 129 (1914) (holding that a surgeon who performs an operation without patient consent commits an assault).

106. Paula Walter, *The Doctrine of Informed Consent: To Inform or Not to Inform?*, 71 ST. JOHN'S L. REV. 543, 545-46 (1997) (citing *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 269 (1990) (citing *Union Pacific R.R. Co. v. Botsford*, 141 U.S. 250, 251 (1891) (“No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to possession and control of his own person from all restraint or interference of others, unless by clear and unquestionable authority of law.”))).

107. See N.Y. PUB. HEALTH LAW § 2805-d (McKinney 2016); N.Y. MENTAL HYG. LAW § 80.03(c) (McKinney 2011) (“Capacity to consent” requires that a person understand his or her condition, the nature and purpose of the proposed and alternative treatments, and the predictable risks and benefits of the proposed and alternative treatments).

under similar circumstances would have disclosed.”¹⁰⁸ To grant informed consent, the patient must (i) be competent, (ii) have the capacity to consent, and (iii) voluntarily give consent, free from coercion.¹⁰⁹ Without all three elements, a person has not given informed consent. And without informed consent, a medical provider may not administer medical treatment absent an emergency.¹¹⁰

A patient may provide informed consent orally, in writing, or a medical provider may infer consent through a patient’s conduct (“e.g., holding out an arm for a shot”).¹¹¹ A medical provider’s failure to obtain informed consent before treatment may result in liability for medical malpractice.¹¹²

“Competency” is an essential element in the laws governing informed consent and patient confidentiality. Competency encompasses the ability of a person to make decisions about her own interests.¹¹³ If a person is not competent, then her decisions have no legal effect.¹¹⁴ Adults are presumed competent unless adjudicated “incompetent.”¹¹⁵ When the state determines that a person’s age or disability interferes with her ability to make decisions for herself, the state may invoke its *parens patriae* power to appoint a legal guardian.¹¹⁶ The state has this power because it has a compelling interest in providing care for citizens who are unable to care for themselves.¹¹⁷

Minors are generally considered incompetent.¹¹⁸ Even though New York law considers any person under eighteen years old to be a minor, the law no longer sets a “blanket” age at which one becomes

108. N.Y. PUB. HEALTH LAW § 2805-d(1) (McKinney 2016). New York State uses the “reasonable physician” standard, rather than the “reasonable patient” standard that has been adopted by a majority of states.

109. See Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15 (1991) (citations omitted).

110. See N.Y. PUB. HEALTH LAW § 2805-d(4)(c) (McKinney 2016).

111. See JESSICA FEIERMAN ET AL., N.Y. CIV. LIBERTIES UNION, TEENAGERS, HEALTH CARE & THE LAW: A GUIDE TO THE LAW ON MINORS’ RIGHTS IN NEW YORK STATE 12 (2001).

112. Section 2805-d, *supra* note 107.

113. Winick, *supra* note 109, at 16.

114. *Id.* at 22.

115. *Id.*

116. See *Mills v. Rogers*, 457 U.S. 291, 296 (1982).

117. *Rivers v. Katz*, 495 N.E.2d 337, 343 (1986) (citing *Addington v. Texas*, 441 U.S. 418, 426 (1979)).

118. See *generally* FED. R. CIV. P. 17(c)(2).

“competent.”¹¹⁹ Courts determine a minor’s “competence” to participate in discrete tasks, such as managing property, standing trial, or consenting to medical treatment.¹²⁰ For example, in New York, a fourteen year old may be competent to testify as a witness,¹²¹ but incompetent to consent to medical treatment.¹²² The next section discusses a minor’s capacity to consent to medical treatment in New York.

B. Minors’ Rights to Consent and the Confidentiality of Medical Treatment in New York

New York law allows minors to consent to medical treatment and receive confidential treatment from a licensed physician—in special circumstances. Policy considerations, including the prevention and treatment of HIV/AIDS, underlie these special circumstances. This section outlines the provisions in New York’s legal code that allow a minor to consent to and receive confidential medical treatment.

1. Minors’ Capacity to Consent to Medical Treatment

New York law defines any person under eighteen years old as a “minor.”¹²³ In general, a minor lacks authority to consent to her own medical treatment.¹²⁴ Instead, medical providers must obtain informed consent from an authorized person, such as a biological or adoptive parent, legal guardian, or caregiver.¹²⁵ “Parental consent” laws are primarily motivated by the perception that minors are not capable of making medical decisions on their own.¹²⁶ Parents also have their own rights, which include the right to custody, care, and

119. See N.Y. GEN. OBLIG. LAW § 1-202 (McKinney 2015); N.Y. C.P.L.R. 105(j) (McKinney 2015).

120. Winick, *supra* note 109, at 23 (citing *Katz*, 495 N.E.2d at 341-43).

121. See *Olshansky v. Prensky*, 172 N.Y.S. 856 (N.Y. App. Div. 1918) (citing *People v. Linzey*, 29 N.Y.S. 560 (N.Y. Sup. Ct. 1894)); 8 Carmody-Wait 2d § 56:160-62.

122. N.Y. PUB. HEALTH LAW § 2504(1) (unless the person is the parent of a child or has married).

123. See N.Y. GEN. OBLIG. LAW § 1-202 (McKinney 2015); N.Y. C.P.L.R. 105(j) (McKinney 2015).

124. See Jennifer L. Rosato, *What Are the Implications of Roper’s Dilemma for Adolescent Health Law?*, 20 J. OF L. & POL’Y 167, 174 (2011); Jennifer L. Rosato, *The Ultimate Test of Autonomy: Should Minors Have a Right to Make Decisions Regarding Life-Sustaining Treatment?*, 49 RUTGERS L. REV. 1, 18 (1996).

125. David M. Vukadinovich, *Minors’ Rights to Consent to Treatment: Navigating the Complexity of State Laws*, 37 J. HEALTH L. 667, 672 (2004).

126. See Rosato, *The Ultimate Test of Autonomy*, *supra* note 124, at 18.

control of their children.¹²⁷ This affects the right of a minor to consent to medical treatment because it typically falls within a parent's constitutional rights to maintain the health and well-being of their child.¹²⁸

New York's Public Health Law, however, builds in two exceptions to parental consent requirements. First, the "status" exception allows a person under eighteen years old to consent to medical treatment if she is a parent, married, serving in the military, or pregnant.¹²⁹ Although pregnant minors may only consent to medical and dental treatment related to their own prenatal care,¹³⁰ upon giving birth, the minor may consent to all forms of medical treatment for herself and her child.¹³¹ In these circumstances, the law presumes that the minor has the requisite capacity to consent to her own medical treatment.

Second, New York law recognizes a "treatment" exception for minors who understand—as perceived by the medical provider—the risk and benefits of reproductive healthcare,¹³² mental health services,¹³³ alcohol and drug abuse services,¹³⁴ and sexual assault treatment.¹³⁵ They may consent to these treatments without parental consent. Two rationales underlie this exception: (1) the recognition of maturity among minors who seek certain treatments and (2) the

127. *Id.*; see also *Wisconsin v. Yoder*, 406 U.S. 205, 234 (1972) (recognizing that the state cannot abrogate a parent's right to raise their children, in particular the state cannot compel parents to send their children under sixteen to formal high school); *Pierce v. Soc'y of Sisters*, 268 U.S. 510, 534-35 (1925) (holding that a state cannot violate due process rights of parents by requiring children attend public school); *Meyer v. Nebraska*, 262 U.S. 390, 399-400 (1923) (holding that the Fourteenth Amendment encompasses the right to bring up children).

128. See Rosato, *The Ultimate Test of Autonomy*, *supra* note 124, at 18 (citing *Lacey v. Lair*, 139 N.E.2d 25, 30 (Ohio 1956)).

129. See generally N.Y. PUB. HEALTH LAW § 2504(1)-(4); N.Y. FAM. CT. ACT § 413 (McKinney 2016); see also *Lowe v. Lowe*, 888 N.Y.S.2d 163, 164 (N.Y. App. Div. 2009).

130. N.Y. PUB. HEALTH LAW § 2504(3) (pregnant minors may consent to "medical, dental, health and hospital services relating to prenatal care").

131. *Id.* at § 2504(1) (male parents also obtain this right upon becoming a parent).

132. *Carey v. Population Servs., Int'l*, 431 U.S. 678 (1977) (holding that the federal right to privacy covers a minor's decision affecting procreation); FEIERMAN ET AL., *supra* note 111, at 15. Reproductive healthcare includes family planning (i.e., birth control and contraceptives), abortion, pregnancy and prenatal care, and care for sexually transmitted infections ("STIs"). See also *State Policies in Brief: Minors' Access to STI Services*, GUTTMACHER INST. (Nov. 2011), <https://www.guttmacher.org/state-policy/explore/minors-access-sti-services> [<https://perma.cc/7F23-4JEX>].

133. N.Y. MENTAL HYG. LAW § 33.21 (McKinney 2011).

134. *Id.* at § 22.11.

135. FEIERMAN ET AL., *supra* note 111, at 15.

barriers that “parental consent” may present to a minor obtaining necessary medical treatment.

At a certain age, minors are “mature” enough to consent to certain medical treatments despite their legal “incapacity.”¹³⁶ “Mature minors” are emotionally and intellectually mature enough to give informed consent, and are recognized as a legal category by the American Medical Association (“AMA”), American Academy of Pediatrics (“AAP”), and by the highest courts of several states.¹³⁷ Generally, when courts consider applying this exception to parental consent requirements they weigh several factors, such as the minor’s age, capabilities, experience, education, training, demeanor, and judgment.¹³⁸ If a minor is seeking medical treatment for reproductive health, mental health, or drug and/or alcohol treatment, courts typically conclude she has already demonstrated a requisite level of maturity. Moreover, sexual activity and drug use are realities for many “legal minors” and, similar to acute health conditions (e.g., reproductive health, mental health, and substance abuse), justify the statutory exceptions to parental consent requirements.

New York courts, however, have not formally recognized the category of “mature minors” who may obtain medical care without parental consent.¹³⁹ Although, in one case, the Queens County Supreme Court applied the mature minor doctrine to determine whether a seventeen year old could refuse blood transfusions on religious grounds.¹⁴⁰ Phillip Malcolm, seven weeks short of his eighteenth birthday, required a blood transfusion, but both Mr. Malcolm and his parents refused to consent to the transfusion because of their beliefs as Jehovah’s Witnesses.¹⁴¹ In response, the

136. See Rosato, *supra* note 124, at 170-71 (collecting literature).

137. See, e.g., *Opinion 5.055: Confidential Care for Minors*, AM. MED. ASS’N J. OF ETHICS (Nov. 2014); *Policy Statement: Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314, 315-16 (1995); *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 837-38 (W. Va. 1992); *In re E.G.*, 549 N.E.2d 322, 328 (Ill. 1989); *Cardwell v. Bechtol*, 724 S.W.2d 739, 745 (Tenn. 1987).

138. Dalizza D. Marques-Lopez, Note, *Not So Gray Anymore: A Mature Minor’s Capacity to Consent to Medical Treatment*, U. OF HOUSTON L. CTR. (2006), [https://www.law.uh.edu/healthlaw/perspectives/2006/\(DM\)MatureMinor.pdf](https://www.law.uh.edu/healthlaw/perspectives/2006/(DM)MatureMinor.pdf) [<https://perma.cc/VLS8-XZY2>].

139. FEIERMAN ET AL., *supra* note 111, at 23. New York also does not have a statute that allows a minor to seek emancipation from her parents. That said, the state has recognized minors as emancipated, so long as they live as if emancipated (i.e., married, in the military, or economically independent). See FEIERMAN ET AL., *supra* note 111, at 20-21.

140. *In re Long Island Jewish Med. Ctr.*, 557 N.Y.S.2d 239, 243 (N.Y. Sup. Ct. 1990).

141. *Id.* at 240.

hospital petitioned the court to authorize its use of necessary medical treatment, including blood transfusions.¹⁴² The court acknowledged that courts in other states, including the Supreme Courts of Illinois and Tennessee, have recognized the existence of the mature minor doctrine¹⁴³ and invited the New York legislature or appellate courts to clarify its validity in New York State.¹⁴⁴ Although the court found merit in the “mature minor” doctrine, it refused to apply it to Phillip Malcolm because, “his refusal to consent to blood transfusions is not based upon a mature understanding of his own religious beliefs or of the factual consequences to himself.”¹⁴⁵ Despite the court’s reluctance to formally recognize the “mature minor” doctrine as applicable in New York, one may interpret Phillip Malcolm’s case to mean that a mature minor standard does exist in New York State because the court held it did not apply to his medical situation.¹⁴⁶

Certain treatment exceptions to parental consent requirements also exist because parental consent may create a “significant barrier” to a minor accessing medical care.¹⁴⁷ Requiring a minor to bring a parent’s attention to her need for medical care related to sexually transmitted infections (“STIs”), pregnancy, or drug use would create volatility within the parent/child relationship.¹⁴⁸ Minors would be more likely to avoid family conflict at the expense of their health.¹⁴⁹ In fact, one study found that when parental notice was mandated,

142. *Id.*

143. *Id.* at 243 (citing *In re E.G.*, 549 N.E.2d 322 (Ill. 1989); *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987)).

144. *Long Island Jewish Med. Ctr.*, 557 N.Y.S.2d at 243 (recognizing that minors may consent to outpatient mental health services, treatment for substance abuse and sexually transmitted infections, and prenatal care or child care for minors with children). The court also recognized New York’s statutory exceptions to the parental consent law.

145. *Id.* (“It is recommended that the legislature or the appellate courts take a hard look at the ‘mature minor’ doctrine and make it either statutory or decision law in New York State.”). The court also recommended that the determination of whether the minor is, in fact, a mature minor should first be established through a preliminary hearing; only then should the substance of the matter be adjudicated. *Id.* at 243 n.16.

146. FEIERMAN ET AL., *supra* note 111, at 23.

147. *Id.* at 16.

148. OFF. OF TECH. ASSESSMENT, U.S. CONG., ADOLESCENT HEALTH-VOL. III: CROSS-CUTTING ISSUES IN THE DELIVERY OF HEALTH AND RELATED SERVICES 134 (June 1991), http://govinfo.library.unt.edu/ota/Ota_2/DATA/1991/9104.PDF [<https://perma.cc/25L3-KYHR>].

149. *See* FEIERMAN ET AL., *supra* note 111, at 23.

fewer than twenty percent of adolescents sought medical care for STIs, pregnancies, or drug use.¹⁵⁰

Medical providers recognize that facilitating access to confidential care for STIs prevents harm to both the minor's health and the public health because STIs may be easily transmitted.¹⁵¹ Allowing minors to consent to STI treatment enhances the speed of the treatment process and helps contain a possible epidemic.¹⁵² Currently, preventing the harms associated with foregoing mental health (or pre-natal care) and substance abuse motivate the statutory exceptions to parental consent. Mental health and substance abuse services are available to minors because, when left untreated, both conditions may result in harm to both the minor and others.¹⁵³ Further, parental consent is often not practical in treating a minor during periods of extreme emotional distress or acute drug use.¹⁵⁴ Access to confidential medical services increases the likelihood that a minor seeks treatment.¹⁵⁵ Thus, the state's prerogatives should align with medical providers: quickly treating health conditions, containing possible epidemics, and reducing public health harms, which override parental barriers to consent and warrant the existing legal exceptions.

2. Confidentiality of HIV Testing and Treatment

Medical providers have a duty to keep patient medical information confidential.¹⁵⁶ Disclosure without prior consent constitutes professional misconduct.¹⁵⁷ A minor's right to confidentiality, just like her right to give consent, may be circumscribed. When a parent consents to medical treatment for a minor, information about the treatment is generally disclosed to the parent.¹⁵⁸ Only in the special circumstances where a minor may consent to her own medical treatment, a health care provider may withhold information about that treatment to parents or other outside parties.¹⁵⁹

150. Malizio Marks et al., *Assessment of Health Needs and Willingness to Utilize Health Care Resources of Adolescents in a Suburban Population*, 102 J. PEDIATRICS 456, 459 (1983).

151. Vukadinovich, *supra* note 125, at 671.

152. *Id.* at 686.

153. *Id.* at 682-84.

154. *Id.* at 683-84.

155. *Id.* at 686.

156. 8 N.Y.C.R.R. § 29.1; 10 N.Y.C.R.R. § 405.7(c)(13); *see also* Griffiths v. Metro. St. Ry. Co., 171 N.Y. 106, 111 (1st Dep't 1902).

157. N.Y. EDUC. LAW §§ 6509(9), 6511; 8 N.Y.C.R.R. § 29.1(b)(8) (2011).

158. *See* FEIERMAN ET AL., *supra* note 111, at 25.

159. *See id.* at 26.

There are two exceptions to disclosure when parents provide consent for a minor's medical treatment. First, a medical provider *must not* disclose information that would be detrimental to the provider-patient relationship or the parent-minor relationship.¹⁶⁰ For example, a provider treating a minor for substance abuse must not disclose that medical information to a parent who is likely to disrupt the minor's course of treatment. Second, a medical provider *may* withhold medical information if a minor objects to disclosure and is twelve years old or older.¹⁶¹ In this context, disclosure is within the provider's discretion.

School health services also provide a general exception to disclosure. The federal constitutional right of privacy protected by the Fourteenth Amendment prevents the government and its agents from disclosing a person's private information.¹⁶² While parents generally consent to school-based health services, an adolescent may consent to medical care in school, and the school must keep that medical information confidential.¹⁶³ Federal law, however, only ensures confidentiality for medical and treatment records maintained by school health providers.¹⁶⁴ Health records maintained by school administrators, such as those related to enrollment in school (e.g., state-mandated vaccination records), are accessible to parents.¹⁶⁵ Thus, to ensure confidential medical treatment of minors, school health providers should keep confidential health information separate from general health information related to education.¹⁶⁶

a. Testing and Confidentiality: Article 27-f

In the context of HIV prevention and treatment, concerns about confidentiality and mandated disclosure may determine whether a patient seeks medical care or advice in the first place. In 1989, New York State enacted Article 27-f of the Public Health Law, addressing testing, confidentiality, and disclosure of HIV-related information.¹⁶⁷

160. N.Y. PUB. HEALTH LAW § 18(2)(c).

161. *Id.*

162. *See* Whalen v. Roe, 429 U.S. 589, 599 n.25 (1977); Sterling v. Minersville, 232 F.3d 190, 196-97 (3d Cir. 2000) (holding that disclosure of an individual's sexual orientation by a police officer violated the constitutional right to privacy).

163. *See* FEIERMAN ET AL., *supra* note 111, at 27.

164. *See id.* at 28.

165. *See* 20 U.S.C. § 1232(g) (2013) (denying funds to schools that refuse parents access to student records).

166. FEIERMAN ET AL., *supra* note 111, at 28.

167. N.Y. PUB. HEALTH LAW §§ 2780-87 (McKinney 2015); *see also* Wendy A. Barnhart, Note, *Confidentiality of HIV and AIDS Related Information in New York*, 1 SYRACUSE J. LEGIS. & POL'Y 115, 115 (1995).

Article 27-f mandates “maximum confidentiality”¹⁶⁸ for HIV and AIDS-related information to encourage voluntary testing and treatment, and to protect individuals from diagnosis-based discrimination.¹⁶⁹

Article 27-f promotes a policy that seeks to reduce the social harms (e.g., stigmatization, discrimination, etc.) associated with a diagnosis or treatment.¹⁷⁰ Any possible indication of an HIV infection results in a range of discrimination against that person predicated on “society’s accumulated myths and fears about disability and disease.”¹⁷¹ Indeed, people with HIV experience discrimination in employment, housing, and even dental and medical care unrelated to HIV treatment.¹⁷² Discrimination has such a pervasive impact on individuals, and on society, that many people forgo testing altogether. For example, nearly forty percent of persons at risk of acquiring HIV have not been tested.¹⁷³ Concerns about privacy and discrimination play a significant role in a person’s decision to receive an HIV test—and if that person tests positive, concerns about privacy and discrimination influence their decision to pursue treatment.

HIV testing is an essential precursor to treatment. New York requires a person to give informed consent before an HIV test can be administered.¹⁷⁴ The law specifically requires medical providers to provide information about HIV/AIDS and its treatment, disclose that testing is voluntary and that HIV test results are confidential, and inform the patient that the law prohibits discrimination based on HIV status.¹⁷⁵ The law also requires the person who communicates the test results to counsel, or refer for counseling, the patient on the emotional consequences of test results, discrimination, behavior

168. Human Immunodeficiency Virus and AIDS Related Information—Confidentiality, 1988 N.Y. SESS. LAW SERV. 584 (McKinney) (“The legislature recognizes that maximum confidentiality protection for information related to human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS) is an essential public health measure”).

169. Barnhart, *supra* note 167, at 115.

170. See Scott Burris, *Law and the Social Risk of Health Care: Lessons from HIV Testing*, 61 ALB. L. REV. 831-32 (1998).

171. *Id.* at 831 (citing *Sch. Bd. v. Arline*, 480 U.S. 273, 284 (1987)).

172. *Id.* at 835; see also Hannah R. Fishman, *HIV Confidentiality and Stigma: A Way Forward*, 16 U. PA. J. CONST. L. 199, 201 (2013).

173. Burris, *supra* note 170, at 833.

174. N.Y. PUB. HEALTH LAW § 2781(1) (2015). In 2014, the legislature amended the law and deleted the “written or, where authorized by this subdivision, oral” consent requirement. N.Y. LAWS 2014, ch. 60 (Part A), § 2.

175. N.Y. PUB. HEALTH LAW § 2781(3)(a)-(g).

change, medical treatment, and the need to notify contacts.¹⁷⁶ New York's HIV informed consent law attempts to ensure that patients understand the "full range of social risks and medical benefits to be found in consenting to [the HIV test]."¹⁷⁷ Through confidentiality protections, it encourages testing and treatment.¹⁷⁸

The statute, however, contains a contradiction in its treatment of minors. Although Article 27-f authorizes minors to consent to HIV testing without parental consent,¹⁷⁹ it effectively prohibits minors from receiving HIV-related treatment without parental consent.¹⁸⁰ The statute defines "capacity to consent" as "an individual's ability, *determined without regard to the individual's age*, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure"¹⁸¹ Thus, the statute defines informed consent without regard to age. Nevertheless, the statute contemplates disclosure to a minor's parents by expressly authorizing medical providers to disclose information to "a person authorized pursuant to law to consent to health care for the individual."¹⁸²

Once a medical provider receives HIV-related information about an individual, the provider must decide whether disclosure to anyone other than the patient is "medically necessary in order to provide timely care and treatment."¹⁸³ Because Article 27-f does not explicitly provide minors with a right to consent to treatment, the medical provider may determine that disclosure is "medically necessary" if the minor requires HIV-related treatment, but refuses to disclose her status to her parent or guardian. Before disclosing, however, the medical provider must give the minor "appropriate

176. *Id.* § 2781(5); see also Elizabeth B. Cooper, *Testing for Genetic Traits: The Need for a New Legal Doctrine of Informed Consent*, 58 MD. L. REV. 346, 396-97 (1999).

177. Cooper, *supra* note 176, at 397.

178. See generally Cooper, *supra* note 176, at 400.

179. N.Y. PUB. HEALTH LAW § 2781-(a)(1).

180. See LEGAL ACTION CTR., HIV/AIDS TESTING, CONFIDENTIALITY & DISCRIMINATION: WHAT YOU NEED TO KNOW ABOUT NEW YORK LAW 9 (2nd ed. 2012) (stating that Public Health Law Article 27-f does not authorize a minor to consent to HIV-related treatment); but see Wing Wah Ho et al., *Complexities in HIV Consent in Adolescents*, 44 CLINICAL PEDIATRICS 473, 476 (2005) (stating that a minor's right to treatment is not clearly defined by the laws in New York, but advocates argue that the basis for consent exists in law); see also Laura Gerace & Max Colmers, *Untitled Report on Article 27-f* (2012) (on file with authors).

181. N.Y. PUB. HEALTH LAW § 2780(5) (emphasis added).

182. *Id.* at § 2782(1)(a); see also Gerace & Colmers, *supra* note 180.

183. N.Y. PUB. HEALTH LAW § 2782(4)(e)(1).

counseling as to the need for such disclosure.”¹⁸⁴ If the provider determines that disclosure would not be in the minor’s “best interest,” the law prohibits disclosure.¹⁸⁵

As written, Article 27-f creates a treatment conundrum. The law mandates that a medical provider arrange for medical treatment for an HIV-positive individual—with that individual’s consent or another’s consent as authorized by law.¹⁸⁶ However, as discussed above, disclosure of a minor’s HIV status may create volatility within the parent-child relationship.¹⁸⁷ Thus, medical providers confront the statutory mandates for disclosure, but must also keep a minor’s “best interests” in mind.¹⁸⁸ Given this tension in the law, many providers believe that minors should receive HIV treatment because withholding treatment until consent is given by a parent might drive a minor from care altogether.¹⁸⁹

b. Treating HIV As an STI So Minors May Consent Without Parental Involvement

In New York, minors may consent to medical treatment related to their reproductive health, mental health, or substance abuse.¹⁹⁰ Reproductive healthcare is broadly defined and ranges from providing birth control to treating STIs.¹⁹¹ If HIV were classified as an STI, minors would be able to seek HIV-related treatment without parental consent as part of their reproductive healthcare. There are historical reasons, however, why this approach has not yet been adopted.

In the 1990s, the DOH decided against classifying HIV and AIDS as STIs as a means of furthering public health. By refusing to make the classification, the DOH ensured that laws concerning reporting and testing would not come into play.¹⁹² DOH’s classification took

184. *Id.* at § 2782(4)(e).

185. *Id.*

186. *Id.* at § 2781.

187. See discussion *supra* Section II.B.1.

188. See N.Y. PUB. HEALTH LAW § 2782(4)(e).

189. See Gerace & Colmers, *supra* note 180. (discussing interview with healthcare provider and adolescent AIDS expert at New York area hospital in September 2011).

190. The right of minors to consent to reproductive healthcare without parental involvement is derived from the federal right to privacy. See N.Y. MENTAL HYG. LAW § 33.21 (right to consent to mental healthcare); N.Y. MENTAL HYG. LAW § 22.11 (right to consent to substance use or alcohol treatment); *Carey v. Population Servs. Int’l*, 431 U.S. 678 (1977); see also FEIERMAN ET AL., *supra* note 111, at 15.

191. FEIERMAN ET AL., *supra* note 111, at 15.

192. N.Y. St. Soc’y of Surgeons v. Axelrod, 572 N.E.2d 605 (1991). Today, the risk associated with driving the epidemic “further underground” has lessened. New York

place early in the epidemic, before much of the currently available treatment options, and reflected the concern among public health experts that classifying HIV as an STI had the potential to exacerbate the stigma attached to HIV infection and drive the epidemic further underground.¹⁹³

In response, the Society of Surgeons¹⁹⁴ sued the DOH, alleging that the agency's Commissioner acted outside of the realm of his authority in failing to classify HIV as a Sexually Transmitted Disease ("STD," i.e., STI).¹⁹⁵ New York's Court of Appeals disagreed.¹⁹⁶ The court applied the deferential standard of review to which state agencies are entitled and held that determining which conditions should be classified as STIs fell within the DOH's discretionary powers and that the Commissioner had not abused his discretion.¹⁹⁷ But, in the last year, Governor Cuomo has proposed amending the DOH's classification to facilitate youth access to HIV-related medication, which could enable minors to more readily access PrEP.

c. Governor Andrew Cuomo's 2016 Proposal

In February 2016, New York Governor Andrew Cuomo proposed new policies to change parental consent laws for HIV-positive teens in need of treatment¹⁹⁸ as part of a broader policy to end the AIDS epidemic in New York by 2020.¹⁹⁹ To combat HIV infections among

State allows public health officials to discuss partner notification with HIV infected patients, prioritizing new diagnoses. Partners include spouses, sexual contacts, or needle-sharing contacts. Patients are asked to voluntarily notify partners or provide partner names for notification purposes. Partners are informed in person. *See* N.Y. ST. DEPT OF HEALTH, *HIV Reporting and Partner Notification Questions and Answers* (2013), https://www.health.ny.gov/diseases/aids/providers/regulations/reporting_and_notification/question_answer.htm#fiftyfive [<https://perma.cc/FZS9-CCEJ>].

193. Scott Burris, *Driving the Epidemic Underground? A New Look at Law and the Social Risk of HIV Testing*, 12 AIDS & PUB. POL'Y J. 66 (1997).

194. The petitioner, New York State Society of Surgeons, consisted of four medical societies that consist of New York State physicians. *Axelrod*, 572 N.E.2d at 606.

195. Sexually Transmitted Infections ("STIs") more accurately describe medical conditions that result from sexual activity. As opposed to Sexually Transmitted Diseases ("STDs"), STIs encompass curable infections, which may not cause any symptoms. STDs, on the other hand, alter typical bodily functions.

196. *See generally Axelrod*, 572 N.E.2d at 605.

197. *Id.* at 606.

198. GOVERNOR ANDREW M. CUOMO, BUILT TO LEAD: 2016 STATE OF THE STATE 257-59 (2016), https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/2016_State_of_the_State_Book.pdf [<https://perma.cc/UY7A-MFBS>].

199. Jordyn Taylor, *NY Gov. Cuomo Is Fighting the Laws Preventing Teens From Getting Treatment for HIV*, MIC (Jan. 21, 2016), <http://mic.com/articles/133128/ny-gov-cuomo-is-fighting-the-laws-preventing-teens-from-getting-treatment-for-hiv#.JxNZkcezd> [<https://perma.cc/DB44-ED5A>]. Ending the epidemic would mean

teenagers and expand access to treatment, the Governor proposed to reclassify HIV as an STI, which would allow minors to consent to treatment.²⁰⁰ Governor Cuomo's proposal also sought to expand access to HIV preventative services to all New Yorkers. If approved by New York's legislature, minors would be able to access PrEP without parental consent under the reproductive health exception to parental consent laws.²⁰¹

Governor Cuomo's proposal recognizes that expanding the means for a minor to access PrEP is central to the "ending the epidemic" campaign. New York has been recognized as a leader in the country by advancing public health policies related to the prevention and treatment of HIV. Most recently, New York also has been recognized as a national leader in its effort to expand access to PrEP.²⁰² Since June 2014, PrEP use among Medicaid enrollees has increased 400 percent.²⁰³ The Governor's February 2016 policy proposal converges with the policy proposal put forward by this Article. But, as policymakers debate reclassifying HIV as an STI, minors should still have access to PrEP without parental consent as a reproductive right, guaranteeing privacy in receiving health services related to reproductive healthcare.

III. BIRTH CONTROL

Reproductive rights are constitutional rights that protect both adults and minors. As Justice Blackmun wrote in *Planned*

reducing the number of new HIV infections to 750 or fewer each year. *Id.*; see also N.Y. ST. DEP'T OF HEALTH, ENDING THE AIDS EPIDEMIC IN NEW YORK STATE (2016), http://www.health.ny.gov/diseases/aids/ending_the_epidemic/ [<https://perma.cc/F4LB-45US>]. In 2009, New York saw 4609 new HIV infections, but by 2013 that number had been reduced to 3512. See BUREAU OF HIV/AIDS EPIDEMIOLOGY, AIDS INST., N.Y. ST. DEP'T OF HEALTH, NEW YORK STATE HIV/AIDS SURVEILLANCE ANNUAL REPORT: FOR CASES DIAGNOSED THROUGH DECEMBER 2013 (2015), http://www.health.ny.gov/diseases/aids/general/statistics/annual/2013/2013-12_annual_surveillance_report.pdf [<https://perma.cc/HP5A-LGQS>]. New York State has allocated \$2.5 billion, with an additional \$200 million from the executive budget, toward combatting HIV/AIDS in the state. *Governor Cuomo Announces Next Phase of State's Plan to End the AIDS Epidemic*, PRESS OFF. OF GOVERNOR ANDREW CUOMO (Nov. 30, 2015), <https://www.governor.ny.gov/news/governor-cuomo-announces-next-phase-states-plan-end-aids-epidemic> [<https://perma.cc/P7PP-WSXV>].

200. *Governor Cuomo Announces Proposal Increasing Access to HIV Treatment for Teens*, PRESS OFF. OF GOVERNOR ANDREW CUOMO (Feb. 11, 2016), <https://www.governor.ny.gov/news/governor-cuomo-announces-proposal-increasing-access-hiv-treatment-teens> [<https://perma.cc/LZX8-G673>].

201. *Id.*

202. *Id.*

203. *Id.*

Parenthood of Central Missouri v. Danforth, “constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority.”²⁰⁴ Reproductive rights exist within the constitutional right to privacy. Both adults and minors share the constitutional right to privacy.²⁰⁵ The right to privacy ensures individual autonomy in rendering life-altering decisions, such as whether to receive medical treatment, marry, or procreate (i.e., reproductive rights).²⁰⁶ Minors, therefore, have a right to privacy, which manifests as patient-physician confidentiality in the medical context.²⁰⁷ Although recent Supreme Court decisions have provisionally limited the right to privacy,²⁰⁸ minors still have reproductive rights that include access to confidential medical or contraceptive services without the need for parental consent.²⁰⁹

This Part discusses the reproductive rights of minors by addressing the key case law defining the framework of reproductive rights. It concludes with a discussion of the law’s social impact, including a

204. 428 U.S. 52, 75 (1976).

205. *See* *Griswold v. Connecticut*, 381 U.S. 479, 484-86 (1965) (holding that a statute prohibiting the use of contraceptives by married couples violated the constitutional right to marital privacy); *see also* *Planned Parenthood of Cent. Mo.*, 428 U.S. at 74 (holding that the state may not impose a “blanket provision” requiring parental consent for an abortion); *Roe v. Wade*, 410 U.S. 113 (1973) (recognizing that the right to privacy covers, with some limitations, the decision to bear a child or terminate a pregnancy).

206. *Carey v. Population Servs. Int’l*, 431 U.S. 678, 685 (1977) (collecting cases).

207. *See* GUTTMACHER INST., *Minors’ Access to Contraceptive Services* (Oct. 1, 2016), <https://www.guttmacher.org/state-policy/explore/minors-access-contraceptive-services> [<https://perma.cc/5LFP-PGCJ>].

208. *See, e.g., Webster v. Reprod. Health Servs.*, 492 U.S. 490 (1989) (upholding Missouri law that forbade the use of public facilities for all abortions, except as necessary to save a woman’s life, and required physicians to perform viability tests on fetuses after twenty weeks of gestation); *Hodgson v. Minnesota*, 497 U.S. 417 (1990) (holding that teens may obtain court authorization for an abortion instead of complying with parental notification laws); *Rust v. Sullivan*, 500 U.S. 173 (1991) (barring abortion counseling and referral by family planning programs funded under Title X of the federal Public Health Service Act); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992) (establishing the “undue burden test” that would allow state regulation of abortion as long as it does not place a “substantial obstacle in path of a woman seeking an abortion of a nonviable fetus”); *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320 (2006) (vacating and remanding New Hampshire law requiring teens to wait forty-eight hours after parental notification for an abortion because there was no medical emergency exception); *Gonzales v. Carhart*, 550 U.S. 124 (2007) (upholding Partial-Birth Abortion Ban Act of 2003 and, in the face of medical uncertainty, allowing lawmakers to overrule doctor’s medical judgment to “promot[e] respect for human life at all stages in the pregnancy”).

209. *See* GUTTMACHER INST., *Minors’ Access to Contraceptive Services*, *supra* note 207.

reduction in teenage pregnancies and changes in popular attitudes toward birth control.

A. Background: Minors' Reproductive Rights

Reproductive healthcare is relevant to both minors and adults. Nearly half (forty-six percent) of teenagers, between fifteen and nineteen years old, are sexually active (i.e., have had sex at least once).²¹⁰ By age eighteen, most young Americans have had sex.²¹¹ Although parental involvement in a minor's medical care often is prudent, mandated parental involvement in a minor's reproductive healthcare could result in many minors forgoing treatment while remaining sexually active.²¹²

The law recognizes this social reality. Twenty-one states and the District of Columbia allow minors to consent to obtaining contraceptive services²¹³ without the involvement of a parent or guardian.²¹⁴ Other states require unique circumstances to exist before a minor, on her own, may access contraceptive services. These exceptions include physician-determined necessity, marriage, pregnancy or motherhood, or satisfying a "mature minor" determination.²¹⁵ Four states, however, have no explicit policy on a minor's capacity to consent to contraceptive services.²¹⁶

210. *American Teens' Sexual and Reproductive Health*, GUTTMACHER INST. (Sept. 2016), <https://www.guttmacher.org/fact-sheet/american-teens-sexual-and-reproductive-health> [<https://perma.cc/EQS9-2W58>].

211. *Id.*

212. See GUTTMACHER INST., *Minors' Access to Contraceptive Services*, *supra* note 207.

213. The Guttmacher Institute has identified the following as "contraceptive services:" oral contraceptives (birth control or morning after pill), injectable, male condom, natural family planning, vaginal ring, patch, spermicide, IUD, copper IUD, hormonal IUD, diaphragm or cervical cap, and sponge. See Jennifer J. Frost et al., *supra* note 13.

214. GUTTMACHER INST., *Minors' Access to Contraceptive Services*, *supra* note 207. Those states include Alaska, Arizona, Arkansas, California, Colorado, Georgia, Idaho, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, Montana, New Mexico, New York, North Carolina, Oregon, Tennessee, Virginia, Washington, and Wyoming. *Id.* Access to abortion for minors is legally more complex. Most states require parental consent or notification. Minors, however, have the constitutional right to obtain a judicial bypass to parental consent requirements. See *Hodgson v. Minnesota*, 497 U.S. 417 (1990). The policy goal of not deterring minors from seeking health care often motivates policies that eliminate parental consent requirements. See B. Jessie Hill, *Medical Decision Making by and on Behalf of Adolescents: Reconsidering First Principles*, 15 J. HEALTH CARE L. & POL'Y 37, 42-43 (2012).

215. GUTTMACHER INST., *Minors' Access to Contraceptive Services*, *supra* note 207.

216. *Id.* Those states are North Dakota, Ohio, Rhode Island, and Wisconsin.

The U.S. Supreme Court has recognized a constitutional right to privacy for certain decisions that applies to both minors and adults.²¹⁷ In 1965, *Griswold v. Connecticut* first recognized a constitutional right to privacy in the penumbra of the First, Third, Fourth, Fifth, and Ninth Amendments,²¹⁸ holding that Connecticut could not restrict a married couple's access to birth control²¹⁹ without intruding on the constitutional right to marital privacy.²²⁰ Seven years later, *Eisenstadt v. Baird* extended *Griswold's* privacy protections by invalidating a state statute that prohibited the sale of contraceptives to unmarried couples.²²¹ *Eisenstadt* found that the "goals of deterring premarital sex and regulating the distribution of potentially harmful articles" were insufficient state interests to justify the legislation.²²²

The constitutional right to privacy guarantees independence from government interference in making important decisions about marriage, procreation, contraception, and child rearing.²²³ In particular, this right to privacy provides the foundation for a minor's right to obtain contraceptive services.²²⁴

When New York tried to regulate a minor's access to contraceptive services, the U.S. Supreme Court struck down the law. In *Carey v. Population Services, Int'l*, the Supreme Court invalidated a provision in New York's Education Law that prohibited the advertising or sale of non-prescription contraceptives to persons under sixteen years old.²²⁵ The Court held that a law burdening the fundamental decision

217. See *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976) (holding that the state may not impose a "blanket provision" requiring parental consent for an abortion); *Griswold v. Connecticut*, 381 U.S. 479, 484-85 (1965) (holding that a statute prohibiting the use of contraceptives by married couples violated the constitutional right to marital privacy); *Roe v. Wade*, 410 U.S. 113 (1973) (recognizing that the right to privacy covers the decision to bear a child or terminate a pregnancy).

218. 381 U.S. at 479.

219. *Id.* at 486.

220. *Id.*

221. 405 U.S. 438 (1972).

222. *Id.* at 443.

223. *Carey v. Population Servs. Int'l*, 431 U.S. 678, 684-85 (1977) (collecting cases). "Child rearing" involves the custody, care, and control of a child, which has also appeared in cases that address a parent's decision on how to educate their child. See, e.g., *Wisconsin v. Yoder*, 406 U.S. 205, 234-35 (1972) (recognizing that a state cannot compel parents to send children to formal high school until age sixteen).

224. *Carey*, 431 U.S. at 694 (holding that blanket parental consent requirements on contraceptive services were unconstitutional); see also *Eisenstadt*, 405 U.S. at 453-55 (holding that the prohibition of contraceptive services to single individuals, as opposed to the married couples in *Griswold*, violates the Fourteenth Amendment).

225. 431 U.S. at 678.

to “bear or beget a child . . . may be justified only by compelling state interests, and must be narrowly drawn to express only those interests.”²²⁶ However, a state restriction on the privacy rights of minors is less rigorous, and only requires a “significant,” not compelling, state interest because the state has “greater latitude to regulate the conduct of children.”²²⁷ In *Carey*, the state’s goal of deterring sexual activity among minors did not satisfy the “significant” state interest standard.²²⁸ Absent a medical necessity to prohibit the distribution of contraceptives to minors, a third party veto—or “blanket” parental consent requirement—was unconstitutional.²²⁹ Since *Carey*, New York State has not imposed any restrictions on a minor’s right to access contraceptive services.²³⁰

Although *Carey* held that a state may not prohibit a minor from accessing contraception absent a compelling state interest, the Court did not address a minor’s right to access contraception when parents or guardians disapprove.²³¹ At least one court has implied that such a right exists.²³² In *Arneith v. Gross*, the Southern District of New York held that a minor’s constitutional right to privacy includes the right to use birth control.²³³

Additionally, through Medicaid and Title X, the federal government funds clinics that make family planning services available

226. *Id.* at 686; *see also* *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, at 859 (1992) (quoting *Carey*, 431 U.S. at 684-85).

227. *Carey*, 431 U.S. at 693 n.15 (citing *Prince v. Massachusetts*, 321 U.S. 158 (1944); *Ginsberg v. New York*, 390 U.S. 629 (1968)).

228. *Carey*, 431 U.S. at 701-02. In *Casey*, the Supreme Court invalidated Pennsylvania’s Abortion Control Act, which required notification of a woman’s spouse before undergoing an abortion. 505 U.S. at 895. *Casey* found that the spousal notification requirement would likely prevent a significant number of women from obtaining an abortion—that is, it constituted a “substantial obstacle.” *Id.* at 893-94. The Abortion Control Act, therefore, placed an undue burden on a woman’s right to reproductive healthcare. *Id.* at 895.

229. *Carey*, 431 U.S. at 693-94; *but see* *Alfonso v. Fernandez*, 606 N.Y.S.2d 259 (N.Y. App. Div. 1993) (holding that condom availability programs in public schools must contain a parental opt-out provision). The implicit “parental consent” requirement in *Alfonso*, however, cannot abrogate minors’ rights under the Constitution. *See* FEIERMAN ET AL., *supra* note 111, at 38 n.87.

230. FEIERMAN ET AL., *supra* note 111, at 38.

231. B. Jessie Hill, *Constituting Children’s Bodily Integrity*, 64 DUKE L.J. 1295, 1307 (2015).

232. *See, e.g.,* *Arneith v. Gross*, 699 F. Supp. 450, 452 (S.D.N.Y. 1988); *see also* Brenda D. Hofman, Note, *The Squeal Rule: Statutory Resolution and Constitutional Implications – Burdening the Minor’s Right of Privacy*, 1984 DUKE L. J. 1325, 1352 (1984).

233. *Arneith*, 699 F. Supp. at 452.

to anyone regardless of age.²³⁴ These programs include confidentiality safeguards for minors that enable clinics to provide contraceptive or reproductive health services without involving parents.²³⁵ If a minor seeks contraceptive services through a Title X health provider, federal law requires that the provider must not disclose the details of the minor's care to their parents.²³⁶

Minors generally do not have a constitutional right to consent to therapeutic or non-therapeutic medical interventions.²³⁷ In New York State, reproductive healthcare—from birth control to STI treatment—is an exception to parental consent laws.²³⁸ HIV-prophylactic medication, such as PrEP, should fall within the existing reproductive health exception.²³⁹ The state DOH—through executive order or otherwise—can use a regulatory definition to place PrEP in the current reproductive healthcare category. Strategic litigation is also an option to move PrEP within the category of reproductive healthcare. Similar to birth control preventing pregnancies, preventing HIV infections works against detrimental long-term health consequences. As the next section discusses, the success of the birth control pill is an important example.

B. Outcomes of Permitting Teen Access to Birth Control

The constitutional right to privacy protecting a person's access to contraceptive services has reduced teen pregnancies and provided women with more control over their reproductive health. Between 1990 and 2008, the United States' rate of teenage pregnancy dropped by forty-two percent.²⁴⁰ For women aged fifteen to nineteen years

234. See 42 U.S.C. § 300, 1396; see also Heather Boonstra & Elizabeth Nash, *Minors and the Right to Consent to Health Care*, GUTTMACHER INST. (2000), <http://www.guttmacher.org/pubs/tgr/03/4/gr030404.html> [<https://perma.cc/Y4EC-6W65>].

235. See *New York v. Heckler*, 719 F.2d 1191, 1196 (2d Cir. 1983); Boonstra & Nash, *supra* note 234.

236. See Boonstra & Nash, *supra* note 234.

237. Hill, *supra* note 231, at 1313.

238. See generally FEIERMAN ET AL., *supra* note 111, at 37-43.

239. Mental health services, drug treatment, STI treatment, and pre-natal care are also exceptions to parental consent laws. Although analogously relevant to receiving HIV treatment, this Article does not engage in an analysis of "treatment." The possibility for such an argument, however, should not be foreclosed. Instead, the focus of this Article is on the "preventative" function of certain reproductive health services. Birth control's preventative or prophylactic function resembles PrEP in practice and in law. See discussion *infra* Section IV.A.

240. See PLANNED PARENTHOOD, *REDUCING TEENAGE PREGNANCY 4* (July 2013), https://www.plannedparenthood.org/files/6813/9611/7632/Reducing_Teen_Pregnancy.pdf [<https://perma.cc/BP3K-4KK3>].

old, this meant a decrease from 117 pregnancies per 1000 women to 67.8 per 1000.²⁴¹ Additionally, between 1990 and 2008, use of the birth control pill increased from nineteen to thirty-nine percent among fifteen to seventeen year olds, and together with increased condom usage, has been found responsible for a seventy-seven percent decline in teenage pregnancies in that age group.²⁴² Through 2002, the increased and better use of contraception among teens can account for up to eighty-six percent of the decline in teenage pregnancies.²⁴³

Beyond a reduction in the rate of teenage pregnancies, the advent of the birth control pill has had far-reaching social consequences. Despite initial concerns that the convenience of the pill would promote promiscuity,²⁴⁴ the pill's greatest impact has been social and economic. For example, birth control is one of the most transformational developments in the business sector in the twentieth century.²⁴⁵ One-third of the wage gains women have made since the introduction of the pill in the 1960s have been the result of access to this form of contraception.²⁴⁶ Absent access to the pill, one estimate suggests the decrease in the gap between men and women's annual incomes "would have been 10 percent smaller in the 1980s and 30 percent smaller in the 1990s."²⁴⁷ Early access to the pill (i.e., before the age of twenty-one) is also a major factor that enables women to pursue higher education.²⁴⁸ In 1970, college enrollment was twenty percent higher among women who could access the pill legally by the

241. *Id.*

242. *See id.*

243. *See id.*

244. *See Contraception: Freedom from Fear*, TIME (Apr. 7, 1967), <http://content.time.com/time/subscriber/article/0,33009,843551,00.html> [<https://perma.cc/A4SQ-BZZD>].

245. Kurt Soller, *The Birth Control Pill Advanced Women's Economic Freedom*, BLOOMBERG BUSINESSWEEK (Dec. 4, 2014), <http://www.businessweek.com/articles/2014-12-04/birth-control-pill-advanced-womens-economic-freedom> [<https://perma.cc/B53Q-B9NK>].

246. *Birth Control Has Expanded Opportunity for Women—In Economic Advancement, Educational Attainment, and Health Outcomes*, PLANNED PARENTHOOD (June 2015), https://www.plannedparenthood.org/files/1614/3275/8659/BC_factsheet_may2015_updated_1.pdf [<https://perma.cc/4AW8-4XRM>].

247. *Id.* at 1 (citing Adam Sonfield et al., *The Social and Economic Benefits of Women's Ability To Determine Whether and When to Have Children*, GUTTMACHER INST. (2013); Martha J. Bailey et al., *The Opt-In Revolution? Contraception and the Gender Gap in Wages*, NBER Working Paper, No. 17922 (2012)).

248. *See* Adam Sonfield et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, GUTTMACHER INST. (2013).

age of eighteen, compared with women who were barred from accessing it by law before the age of twenty-one.²⁴⁹ Young women's legal access to the pill before the age of twenty-one also led to an increase in women who graduated from college.²⁵⁰

The pill permitted young women to control their reproductive lives and changed the balance of power between men and women in American society, significantly furthering the pursuit of gender equality and female autonomy.²⁵¹ Generally, when individuals are able to delay having children and can choose to have fewer of them, "they tend to be more financially secure and better able to help their children succeed."²⁵² The social and health-related benefits of expanding access to the birth control pill are clear. Comparably, expanding the definition of reproductive healthcare to include access to HIV-preventative medication could effectuate similar social and health-related outcomes among MSM thirteen to twenty-four year olds, especially those living in communities of color.

IV. CREATING A PREP EXCEPTION IN NEW YORK STATE LAW

Access to PrEP should fall within the reproductive health exception to a minor's capacity to consent to medical care. Currently, New York State classifies PrEP as HIV-related treatment. As such, minors cannot readily access it without parental consent. Yet, PrEP prevents HIV infections as effectively, if not more effectively, than the pill prevents pregnancies. Although critics have expressed concern about the side effects from long-term PrEP use, the potential reduction in new HIV infections outweighs these concerns. This section analyzes PrEP through a reproductive rights framework. It also addresses and dispels the potential concerns with providing minors access to PrEP.

249. See PLANNED PARENTHOOD, *supra* note 246, at 1 (citing Adam Sonfield et al., *supra* note 248; Martha J. Bailey et al., *supra* note 247).

250. See PLANNED PARENTHOOD, *supra* note 246; Elizabeth O. Ananat & Daniel M. Hungerman, *The Power of the Pill for the Next Generation: Oral Contraception's Effects on Fertility, Abortion, and Maternal and Child Characteristics*, 94 REV. OF ECON. & STAT. 37, 37-51 (2012).

251. Jaclyn Trop, *50 Years of Legal Birth Control: How it Changed the Workplace for Women*, FORTUNE (June 7, 2015), <http://fortune.com/2015/06/07/50-years-legal-birth-control-workplace/> [<https://perma.cc/UAB7-2QDX>].

252. Max Nisen, *The Long-Term, Extremely Positive Effects of Birth Control in America*, BUS. INSIDER (Oct. 7, 2013), <http://www.businessinsider.com/positive-effects-of-birth-control-2013-10> [<https://perma.cc/58ML-PXL9>].

A. PrEP Functionally Resemble Birth Control

The primary similarity between the pill and PrEP is that they are both preventative tools. Individuals use both to shield themselves from adverse bodily consequences. New York's current classification of PrEP as HIV treatment, which precludes minors from accessing it, is a misnomer. Even though Truvada is a combination of two existing medications used to treat HIV, its separately approved use as PrEP also makes the drug a prevention tool as opposed to a treatment option. This difference in function is an important one, acknowledged by the New York State DOH.²⁵³

New York case law currently conflates treatment and prevention, but does so in the context of classifying vaccinations.²⁵⁴ In practice, the DOH distinguishes between treatment and prevention in the context of minors' access to STI treatment.²⁵⁵ The DOH recognizes that preventative measures and treatment after an STI infection occupy different positions on the continuum of care,²⁵⁶ as such, there is no reason to exclude PrEP from this classification as prevention. In classifying PrEP as HIV treatment, the DOH ignores its actual function. It is also logically inconsistent with how New York treats the prevention of STIs—as procedures distinct from treatment of STIs.²⁵⁷

PrEP has numerous differences from HAART therapy (i.e., existing HIV treatment regimens). Apart from the clear functional differences,²⁵⁸ Truvada as PrEP is one pill, taken alone; it has minimal potential side effects, and requires less frequent monitoring by medical professionals.²⁵⁹ Conversely, HAART is a combination of numerous ARVs. HAART treatment requires routine blood testing

253. *Legislative Memo: Regarding Expanding Access to STI Treatment and Prevention for Minors*, N.Y. CIV. LIBERTIES UNION (Apr. 13, 2015), <http://www.nyclu.org/content/regarding-expanding-access-sti-treatment-and-prevention-minors> [<https://perma.cc/Y942-VREH>] (outlining the disparity between minors' ability to access confidential treatment for STIs once infected and their ability to access preventative care at the outset).

254. New York courts have recognized that when the term has been left undefined by the legislature, the plain meaning of treatment encompasses comprehensive preventive treatment. *See, e.g.*, *People v. Steinberg*, 73 N.Y.S.2d 475, 477 (N.Y.C. Ct. 1947) (holding that “vaccination is a treatment given to a human being, even though no disease is present” and the administration of a vaccine is “treatment as well as preventive medicine.”).

255. *See* N.Y. CIV. LIBERTIES UNION, *supra* note 253.

256. *See id.*

257. *See id.*

258. *See* AIDS.GOV, *supra* note 53.

259. *See supra* text accompanying notes 68 and 78.

to check viral load, CD4 counts, CD4/CD8 ratios, and a variety of other factors. HAART treatment also requires more stringent monitoring for general well-being, side effects, and other complications. It involves more medications, more potential side effects and drug interactions, and larger number of blood tests per doctor's visit than are needed for PrEP.²⁶⁰ Adherence to PrEP is simpler than adherence to HAART therapy.²⁶¹ Precluding minors from accessing PrEP by maintaining its classification as HIV treatment ignores the fact that taking a once-daily pill prevents HIV infection.

In addition to the similarity as a mode of prevention, PrEP resembles the birth control pill in other ways that weigh in favor of similar legal treatment. PrEP and the pill are administered similarly; each consists of a daily pill with a similar likelihood of preventing respective adverse consequences (i.e., for PrEP it is an HIV infection, whereas for birth control, it is unwanted pregnancy).²⁶² PrEP and the pill are both harm reduction strategies: the reality that minors will engage in sexual activity, regardless of the risks, demands that the state intervene to mitigate the public health risks involved. Finally, both PrEP and the birth control pill rely on compliance with the daily regimen for the full effect of the prevention therapy to work.²⁶³

Because PrEP is a prevention tactic, it should be distinguished from the HIV treatment known as HAART therapy. Further, there are clear and striking similarities between PrEP and the birth control pill. Each is the functional equivalent of the other and the law should treat the two prophylaxes similarly.

B. Minors Have a Right to Privacy That Covers Access to PrEP

Under New York law, minors may consent to medical care related to their reproductive health without parental notification or consent.²⁶⁴ Reproductive healthcare is an exception to parental consent laws for two reasons: (1) a large portion of teenagers are

260. See generally Katie Peoples, *Myth or Truth: Is There a Difference Between PrEP and Treatment?*, ADVOCATE (Oct. 8, 2014), <http://www.advocate.com/31-days-prep/2014/10/08/myth-or-truth-there-difference-between-prep-and-treatment> [https://perma.cc/N2PN-76YJ].

261. See NAT'L INST. OF ALLERGY & INFECTIOUS DISEASES, *supra* note 51.

262. See *supra* text accompanying notes 67-68.

263. See *supra* text accompanying note 72.

264. See *Carey v. Population Servs. Int'l*, 431 U.S. 678, 694 (1977); see also discussion *supra* Section II.B.2.b.

sexually active²⁶⁵ and (2) parental notification or consent requirements would deter minors from seeking reproductive healthcare.²⁶⁶

Reproductive healthcare is a broad category. It includes services related to birth control, prenatal care, treatment of STIs, and abortions.²⁶⁷ This Article focuses on access to birth control as the key reproductive health service. Because birth control falls within the category of reproductive healthcare, minors have a right to access it without parental interference.

As discussed in Section III.A, the constitutional right to privacy covers medical treatment related to one's reproductive health.²⁶⁸ Through the right to privacy, minors may access birth control without parental consent, and generally, medical providers may not disclose such information to parents.²⁶⁹ The constitutional right to privacy should equally protect a minor's right to access PrEP.

Confidentiality already protects medical information related to an adult's decision whether to receive an HIV-test or treatment.²⁷⁰ Article 27-f exemplifies the importance New York State places on the confidentiality of HIV-related medical information.²⁷¹ These confidentiality provisions exist because medical information is always sensitive, especially HIV-related information, due to social stigma and discrimination.²⁷²

Additionally, in *Carey*, the Supreme Court recognized that a state may not restrict a minor's privacy rights unless such regulation would serve a "significant state interest."²⁷³ The right to privacy covers access to contraceptives, which implicate the fundamental right,

265. See *American Teens' Sexual and Reproductive Health*, GUTTMACHER INST., *supra* note 210; Laura Kann et al. *Youth Behavior Risk Surveillance — United States, 2013*, 63 MORBIDITY & MORTALITY WKLY. REP. 4, 24 (2013).

266. See Malizio Marks et al., *Assessment of Health Needs and Willingness to Utilize Health Care Resources of Adolescents in a Suburban Population*, 102 J. OF PEDIATRICS 456, 459 (1983) (noting that fewer than twenty percent of minors would seek treatment for STIs, pregnancies, or drug use if parental consent was required).

267. See generally *American Teens' Sexual and Reproductive Health*, GUTTMACHER INST., *supra* note 210 (a leading organization in reproductive health advocacy and policy research classing abortion, contraception, HIV and STIs, and pregnancy (including pre-natal care) as categories of reproductive health).

268. See *Carey*, 431 U.S. at 684-85; see also *Roe v. Wade*, 410 U.S. 113, 152-53 (1973); *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965).

269. See N.Y. PUB. HEALTH LAW § 18(2)(c) (McKinney 2010); see also *Carey*, 431 U.S. at 694; *Arnett v. Gross*, 699 F. Supp. 450, 452 (S.D.N.Y. 1988).

270. See discussion *supra* Section II.A.

271. See discussion *supra* Section II.B.2.a.

272. See *Burris*, *supra* note 170, at 831-32.

273. *Carey*, 431 U.S. at 693.

shared by minors and adults, to autonomously make decisions that impact their reproductive life.²⁷⁴ No “significant state interest” exists to restrict a minor’s access to PrEP.²⁷⁵

Carey had previously declared that deterring sexual activity among minors is an insufficient significant interest to preclude their access to contraceptives.²⁷⁶ The same should be true for PrEP. No compelling or significant medical reason exists for restricting a minor’s access to PrEP. The FDA has approved PrEP for public consumption studies on PrEP-related side effects are inconclusive or show minimal harms, and PrEP may be the most efficacious method available to prevent HIV-infection.²⁷⁷

If New York continues to impose barriers limiting a minor’s access to PrEP, the current rates of HIV-infections among thirteen to twenty-four year olds will likely continue. If minors had a reproductive right to access PrEP without parental consent, HIV-infection rates may fall precipitously, similar to the drop in teenage pregnancies once states expanded minors’ access to birth control.²⁷⁸

C. Why the Arguments Against Expanding Access to PrEP Are Wrong

This Article argues for an expansion of reproductive rights in order to reduce the number of HIV-infections among minors in New York State. Critics, however, may raise concerns that relate to existing parental rights, adverse health outcomes, and medication compliance. This Section addresses each concern in turn.

First, critics may invoke the legal rights currently afforded to parents. In general, parents have the right to the care, custody, and control of their children. Several Supreme Court decisions have recognized that the Fourteenth Amendment encompasses a parent’s right to raise their children as the parent chooses.²⁷⁹ In most cases, a

274. *See id.* at 684-85.

275. *See id.* at 693.

276. *See id.* at 695-96; *see also* Eisenstadt v. Baird, 405 U.S. 438, 443 (1972).

277. *See* AIDS INFONET *supra* note 5; Grant, *supra* note 6, at 2593; *see also* Treatment to Prevent HIV Infection (PrEP), AIDS InfoNet, http://aidsinfonet.org/fact_sheets/view/160 [<https://perma.cc/25GR-PK24>].

278. *See* John S. Santelli et al., *Explaining Recent Declines in Adolescent Pregnancy in the United States: The Contribution of Abstinence and Improved Contraceptive Use*, 97 AM. J. PUB. HEALTH 150, 154 (2007).

279. *See* Wisconsin v. Yoder, 406 U.S. 205, 213-14 (1972) (recognizing that state cannot compel parents to send children to formal high school until age sixteen); *see also* Pierce, 268 U.S. at 532 (holding that state cannot violate due process rights of parents by requiring children attend public school); Meyer v. Nebraska, 262 U.S. 390,

parent must consent before a minor receives medical care, which is central to the care of a minor.²⁸⁰ Although care and custody rationales also inform “parental consent” requirements, the Supreme Court has tended to apply such parental rights in the educational context.²⁸¹

Minors’ access to PrEP, however, is different than the traditional circumstances which would require parental consent. PrEP is a medication designed for persons at risk of an HIV infection. Sexually active teenagers are especially at risk.²⁸² Further, many states recognize a distinct category of “mature minors” who have the cognitive ability to make decisions that affect their reproductive health.²⁸³ Even without a legislative “mature minor” category, New York State acknowledges the concept in reproductive decision-making.²⁸⁴ If a minor recognizes that risk, and takes appropriate precautionary action in consultation with a medical provider, then a minor demonstrates a level of maturity comparable to a person eighteen years or older.²⁸⁵ By expanding access to PrEP, the law would affirm the principles of autonomy that underlie informed consent and encourage minors to pursue medical care—the same goals underlying the state’s decision to permit minors to obtain reproductive healthcare without parental consent.

Second, critics may assert that, as is often the case with new drugs on the market, there are unanswered questions surrounding PrEP. The long-term effects of taking Truvada as PrEP are currently unknown. Ordinarily, Truvada has the potential to cause some serious side effects, including lactic acidosis (i.e., build-up of digestive acid), serious liver problems, or a greater likelihood of developing

399-400 (1923) (holding that the Fourteenth Amendment encompasses the right to bring up children); Rosato, *supra* note 124, at 175.

280. See Rosato, *supra* note 124, at 174 (citing *Belotti v. Baird*, 443 U.S. 622 (1979)).

281. See *id.*; see also *Pierce v. Soc’y of Sisters*, 268 U.S. 510, 534-35 (1925).

282. See *HIV Incidence Estimates for New York State 2013*, N.Y. ST. DEP’T OF HEALTH (Dec. 2015), http://www.health.ny.gov/diseases/aids/general/statistics/docs/hiv_incidence_2013.pdf [<https://perma.cc/3Z52-DGC3>].

283. See, e.g., Am. Med. Ass’n, *Confidential Care for Minors*, 16 AM. MED. ASS’N J. 901, 901 (2014); see also Am. Acad. of Pediatrics, *Policy Statement: Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314, 316 (1995); *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 833 (W. Va. 1992); *In re E.G.*, 549 N.E.2d 322, 324 (Ill. 1989); *Cardwell v. Bechtol*, 724 S.W.2d 739, 746 (Tenn. 1987).

284. See N.Y. PUB. HEALTH LAW § 2504(1)-(4) (McKinney 2005).

285. See *supra* text accompanying notes 132–38 (noting that a minor who seeks reproductive health, mental health, and substance abuse treatment demonstrates a requisite level of maturity to overcome parental consent requirements).

either of those.²⁸⁶ Tenofovir, one of the two drugs in Truvada, may also lead to decreased bone density over time.²⁸⁷ The lack of answers, or the potential negative health outcomes, may fuel PrEP's critics, especially when considering whether to permit a minor to access the drug. Similar concerns were raised, and appropriately dispelled, for the birth control pill.²⁸⁸ Although more potent when introduced, the birth control pill became safer over time. Furthermore, the health and social benefits in expanding access to the birth control pill for teens outweighed the potential concern related to its side effects.²⁸⁹ PrEP is similar. PrEP's potential to reduce the risk of HIV infection significantly outweighs the costs of potential negative health outcomes. And, as the medical community continues to research PrEP, it will most likely become safer over time.

As an HIV prevention strategy, PrEP is unparalleled, surpassed in efficacy only by sexual abstinence, which has proven an unreliable public health strategy among teens.²⁹⁰ Concerns about health consequences associated with long-term use should not impede healthy individuals from preserving their health; this is especially true for minors, who will remain sexually active—with or without PrEP as a part of their daily regimen.

Third, another concern some may raise about minors obtaining PrEP is that in order to be fully effective, it requires daily adherence, which may be challenging. Similar arguments have emerged in the context of taking the birth control pill on a daily basis. Education and counseling services have bridged the gap in the birth control context, and they can be similarly effective in the context of PrEP. Over time, teens have come to understand that if they want to avoid pregnancies, they need to maintain their daily regimen.²⁹¹ A considerable reduction in the number of teenage pregnancies supports this

286. See *Important Safety Information*, TRUVADA, <http://www.truvada.com/truvada-side-effects> [<https://perma.cc/9WRV-8CQQ>].

287. See Grigsby et al., *Tenofovir-associated bone density loss*, 6 THERAPEUTICS & CLINICAL RISK MGMT. 41, 42 (2010).

288. See *Freedom from Fear*, 89 TIME 100 (Apr. 7, 1967), <http://content.time.com/time/subscriber/article/0,33009,843551,00.html> [<https://perma.cc/2RW5-X8GH>].

289. See discussion *supra* Section III.B.

290. See ADVOCATES FOR YOUTH, THE TRUTH ABOUT ABSTINENCE-ONLY PROGRAMS (2007), <http://www.advocatesforyouth.org/storage/advfy/documents/fsabstinenceonly.pdf> [<https://perma.cc/N75C-DMJ8>] (noting that abstinence only education in eleven states may have negatively impacted youth's willingness to use contraception to prevent negative sexual health outcomes).

291. Claire Brindis & Laura Davis, *Improving Contraceptive Access for Teens*, 4 ADVOCATES FOR YOUTH 1, 3 (1998) (noting that in recent years, teen contraceptive use and compliance has increased).

understanding. Currently, PrEP is relatively unknown to the groups that may most require it. An increase in education and awareness will likely be as effective as promoting daily adherence to PrEP as it was for the birth control pill.²⁹²

Additionally, the CDC estimates that the cost of lifetime treatment of an HIV infection is \$379,668.²⁹³ PrEP has been shown to be very cost-effective in studies conducted outside of the United States, cementing itself as an important public health strategy for the prevention of HIV transmission among individuals of all ages.²⁹⁴

The legal and medical communities should embrace the expansion of access to PrEP to minors. Doing so will help reduce HIV infections and save lives. But, more significantly, it makes sense from a legal and policy perspective.

CONCLUSION

PrEP's introduction to the market has been an important milestone in the fight against HIV/AIDS. PrEP has reinvigorated the hope that the end of the epidemic is in sight. Governor Andrew Cuomo's administration has endorsed and outlined a plan to expand access to PrEP to minors by reclassifying HIV as an STI. Another viable approach is to include PrEP within the reproductive health exception to parental consent through a DOH regulation or affirmative litigation. PrEP and the birth control pill are functionally similar: both are a once daily pill that ensure a person's reproductive health. The law must recognize this similarity and codify access to PrEP as a matter of reproductive health, ensuring that minors have the ability to access PrEP to protect themselves against HIV. By applying a reproductive rights analysis in this context, New York will be one step closer towards ending the AIDS epidemic and preserving individual autonomy in medical care.

292. *See id.* at 5.

293. *See HIV Cost-effectiveness*, CTRS. FOR DISEASE CONTROL & PREVENTION (2015), <http://www.cdc.gov/hiv/programresources/guidance/costeffectiveness/index.html> [<https://perma.cc/N9M9-4XB9>] (calculating the cost of HIV treatment in 2010 U.S. dollars).

294. *See, e.g.,* Estelle Ouellet et al., *Cost effectiveness of 'on demand HIV pre-exposure prophylaxis for non-injection drug-using men who have sex with men in Canada*, 26 CAN. J. OF INFECTIOUS DISEASES & MED. MICROBIOLOGY 1, 23 (2015) (finding that the average annual total cost of one HIV infection ranged from \$27,410 to \$35,358, while the annual cost of PrEP was \$12,001 per participant, and the amount per life saved was roughly \$621,390 per infection prevention.).