

Headlines from the Hill

Legislating HPV vaccine— A state tale

By Janet Haebler, MSN, RN

The ANA supports legislative efforts that bolster adolescent health. In 2006, the introduction of the first federally approved vaccine to guard against the human papillomavirus (HPV), Gardasil, and subsequent national recommendations by the Centers for Disease Control and Prevention (CDC) set the stage for a flurry of state activity. Forty-one states and the District of Columbia introduced legislation to require, fund, or educate the public about the vaccine. ANA has been tracking the activity and offers guiding principles for evaluating legislation.

HPV is among the most common sexually transmitted infections in the United States and the leading cause of cervical cancer. There are about 100 different strains of HPV; some are associated with cervical cancer, some with genital warts or vulvar or vaginal cancers. The CDC reports that more than 50% of all women will get HPV infection at some time in their life; most of whom will not know it because of asymptomatic strains. Those at greatest risk for HPV infection include females younger than 25 who had multiple sexual partners; who had sexual intercourse at age 16 or younger; or who had sex with a male with multiple sexual partners. The CDC recommends routine vaccination of girls between the ages of 11 and 12 before they become sexually active. Gardasil reportedly provides 100% protection against infection from HPV types 16 and 18, responsible for nearly 70% of all cervical cancers, and protects against HPV types 6 and 11, which cause 90% of genital warts. Results of current studies indicate the protection lasts at least 5 years; it is unknown whether boosters will be needed.

Although the CDC provides recommendations, vaccination requirements are established at the state level. Some states grant regulatory bodies the power to establish vaccination policy, but the legislature determines funding. Much of the policy debate in the states has centered on school mandates, citing concerns about Gardasil's safety and efficacy, parents' right to choose, and associated cost. The three required injections of Gardasil are reported to cost \$360. If mandated, states are concerned about furnishing the vaccine for the uninsured and those cov-

ered by Medicaid or the State Children's Health Insurance Plan and whether insurance plans should be required to provide coverage. Most large health plans cover the costs of "recommended" vaccines, yet there may also be a "catch up" period to extend coverage for the new recommendations. Many have voiced moral objections to a mandate for a vaccine for sexually transmitted disease.

Despite some false starts in 2006 when bills failed in Michigan and Ohio, in 2007 a number of states have enacted legislation, which varies greatly. Although Texas was the first state by executive order to require all females entering the sixth grade to receive the vaccine, legislators responded with an override. The resulting legislation requires schools to distribute medically accurate and unbiased information about the vaccines to parents or legal guardians. The Virginia legislature passed a school vaccine requirement stipulating a child receive the first dose before entering the sixth grade. Following the governor's amendment, parents have the ability to exempt their child. Indiana law does not mandate the vaccine for school attendance but requires parents of girls entering the sixth grade to receive information. Parents then must sign a statement notifying the school of their decision to vaccinate or not and in turn, the school must provide the information to the state health department.

Other states have chosen different legislative approaches. Colorado, Connecticut, and Utah legislated awareness campaigns; Iowa, New Jersey, North Carolina, and Washington require education in the schools; Rhode Island and New Mexico passed laws requiring insurance plans to cover HPV immunization.

ANA believes that deciding whether to support mandating vaccination involves weighing the known benefits against the rights of parents' to consider what is best for their children. ANA recommends that HPV vaccine legislation, at the very least, include provisions for parental choice; the opportunity to "opt out" after having received education about the relationship between HPV and cervical cancer; and provisions for funding and access, should a health plan not provide coverage or if individuals are uninsured. Additionally, ANA supports continued research to monitor the HPV vaccine's efficacy, the development of new vaccines, and the appropriateness for expanding coverage to males. ★

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