JOEL KITCHENS
STATE REPRESENTATIVE • 1ST ASSEMBLY DISTRICT

Testimony for the Assembly Committee on Health
Assembly Bill 36
Thursday, Oct. 7, 2021

Thank you Chairman Sanfelippo and committee members for holding a public hearing and giving me the opportunity to testify on Assembly Bill 36, which will authorize pharmacists to prescribe certain contraceptives.

Under current state law, women can only obtain most birth control through a prescription from a physician or an advanced practice nurse who has met the required qualifications.

AB 36 would, under specific circumstances, allow a woman to obtain hormonal contraceptive patches and self-administered oral hormonal contraceptives, including common birth control pills, through a prescription from a pharmacist.

The rules to establish the standard procedures for pharmacists prescribing contraceptives will be promulgated by the Pharmacy Examining Board, after consulting with the Medical Examining Board, Board of Nursing and Department of Health Services

In order to acquire a prescription for birth control from a pharmacist, the person must complete a self-assessment questionnaire and undergo a blood pressure screening. The questionnaire must be developed in consideration of the guidelines established by the American College of Obstetricians and Gynecologists.

If there are any red flags, the pharmacist is not required to prescribe and dispense birth control and can instead refer the patient to their primary health care practitioner. If the woman is deemed a match, the pharmacist must dispense the contraceptive as soon as practicable and report the prescription to that individual's primary health care practitioners. Participation by pharmacists is voluntary and they will not be required to take part in this program if they have moral objections to birth control.

I will point out that women can currently purchase birth control online after answering a few questions by telephone from a doctor. That process is a far less rigorous than that proscribed in this bill.

This bill only applies to women who are at least 18 years of age.

Capitol Office: Post Office Box 8952 • Madison, WI 53708-8952 • (608) 266-5350 • Toll-Free: (888) 482-0001 • Fax: (608) 282-3601
Rep.Kitchens@legis.wi.gov

One of the reasons we introduced AB 36 is because of the high costs associated with unplanned pregnancies.

According to the latest available statistics, nearly half of pregnancies in both Wisconsin and across the nation are unplanned, with the highest rates reported by women in their 20s and those who live in poverty.

A study from the Guttmacher Institute found that state and federal taxpayers spend about $21 billion annually on unplanned pregnancy-related care, with public insurance programs such as Medicaid financing 68 percent of unintended births, compared to 38 percent of planned births. This figure does not include additional costs that stem from an unplanned pregnancy's impact on educational attainment, family economics and a child's health and well-being.

Almost 63 percent of unplanned births are publically-funded in Wisconsin, with the federal and state governments spending $313.5 million each year on this care. Of that total, $221.4 million is paid for by federal tax dollars and $92.1 million by state tax dollars. The total public cost for unintended pregnancies in Wisconsin is $286 annually for every woman in the state, which is considerably higher than the national average of $201 per woman.

Significant intergenerational health effects also exist with unplanned pregnancies. According to the Institute of Medicine, women with unintended pregnancies are more likely to smoke or drink alcohol during pregnancy, have depression and experience domestic violence. They are also less likely to obtain prenatal care or breastfeed.

Furthermore, short interpregnancy intervals have been associated with adverse neonatal outcomes, including low birth weight and prematurity, which increase the chances of children having health and developmental problems throughout their lives. Plus, these youth are more likely to score worse on behavioral and developmental measures than children who were born as a result of a planned pregnancy.

An unintended pregnancy can also severely disrupt a woman's educational goals, which in turn has a tremendous influence on future earning potential and family financial well-being. Community colleges are typically the place first generation college students begin their post-secondary education. Nationally, unplanned births are the reason 10 percent of women drop out of community college and most never obtain their degree. This perpetuates the intergenerational cycle of poverty.

Knowing all of these sobering facts, we should not be putting up artificial barriers that deny women more choices when it comes to their reproductive healthcare.

When the common birth control pill became available in the United States in the 1960s, you could only obtain the oral contraceptives through a prescription from a doctor. That made sense at the time, particularly since the pills had incredibly high hormone levels and experts were not sure how the medication would affect women physiologically.

Fast-forward almost 60 years and things have definitely changed. Decades of research has shown us that formulations for oral contraceptives have become much more benign. While all drugs come with the potential for harmful side effects – even Aspirin can cause bleeding disorders – the consensus of the medical community is that birth control pills are no more dangerous than ibuprofen.

More than 100 countries across the world allow access to birth control without a prescription. Yet, women in the United States still need a prescription from their doctor or nurse practitioner to be able to obtain birth control pills. Even the morning-after pill, which is seven times more potent than your average oral contraceptive, is available over-the-counter and doesn't require a prescription.

To understand why we need to update our laws in Wisconsin, I would like to explain that there are only two factors that are supposed to be used to determine whether a medication should be prescribed by a physician. Drugs are made prescription-only because they either have high abuse potential or they have a low margin of safety which requires a doctor's oversight.

There is no documentation that birth control pills have ever been abused and the American College of Obstetricians and Gynecologists, American Academy of Family Physicians, the Wisconsin Medical Society, the American Medical Association and the Wisconsin Nurses Association all agree that birth control pills are so safe they should be available over-the-counter and with no prescription. While that may be their preferred direction, only the Federal Food and Drug Administration can make a medication over-the-counter.

Dr. Eliza Bennett, from the UW School of Medicine and Public Health's Department of Obstetrics and Gynecology, said that the "risks associated with pregnancy are infinitely greater than those associated with birth control."

The primary health risk that comes with taking birth control is the potential for developing blood clots. The blood pressure screening performed by the pharmacist will prevent most of these problems. According to the College of OB/Gyns, this problem is easily managed and there are now multiple brands of pills with ultra-low levels of estrogen that avoid this problem. The risk of blood clots is also far greater in pregnancies than birth control.

I have also heard concerns that because birth control pills use hormones to block pregnancy, they may overstimulate breast cells, which can increase the risk of breast cancer. While there in a slight increased risk, especially in older women, a study published by *Cancer Research* shows that using birth control pills with a low dose of estrogen has not been linked to a higher probability of being diagnosed with breast cancer. While saying that birth control pills are a Class I carcinogen for breast cancer sounds ominous, it is worth noting that alcoholic beverages and working the late shift are also listed as Class I carcinogens for breast cancer.

Research also has found that birth control pills can lower the risk of uterine and ovarian cancer by 50 percent. In fact, women with family histories of these two types of cancer are frequently put on birth control as a preventive measure.

I trust the medical community which overwhelmingly believes it is much safer than many current over-the-counter drugs and should be dispensed with no screenings at all.

A couple of groups will testify today who are opposed to any birth control on moral grounds. While I respect their moral convictions, five percent of the population does not have the right to impose their morality on the other 95 percent.

You will hear very misleading data from these groups questioning the safety and efficacy of hormonal birth control. While every major medical group supports this bill, for instance, the Catholic Physicians Guild says it is dangerous to allow pharmacists to prescribe birth control. This is just one example of twisting science to justify a moral position.

I will address a couple of the criticisms you may hear from the opponents of this bill. While these critics may not agree with many of the things I'm about to say, if you have any questions regarding the validity of the forthcoming information, please contact my office and we will be happy to provide you with science-based documentation.

First, they will tell you that birth control is not effective and gives women a false sense of security. There is always room for some human error, but when used consistently and correctly, oral contraceptives are 99.9 percent effective.

In any given year, the two-thirds of American women at risk of unintended pregnancy who use contraceptives regularly throughout the year account for only 5 percent of all unplanned pregnancies. Meanwhile, 95 percent of unintended pregnancies are attributed to the one-third of women who do not use contraceptives or who use them inconsistently.

They may point to a Canadian study that says that most unplanned pregnancies occur in women who are using birth control. What they leave out is that this study considers such unreliable means of preventing pregnancy as the rhythm method and withdrawal to be "birth control."

The primary cause of irregular use is a lack of access. I think it is ironic that the people who oppose increased access to birth control are citing ineffectiveness when that lack of access is the major contributor to failure. Many OBGYNs have told me that women will frequently run out of oral contraceptives and cannot get an appointment with their doctors in a timely fashion. A large number of women also forget to bring their pills with them when they go on vacation. This bill will help alleviate that.

Some opponents are also claiming that birth control pills are an abortifacient that works by blocking the implantation of a viable embryo. However, that claim is purely hypothetical – there is no scientific evidence that oral contraceptives work this way.

Birth control pills stop pregnancies from happening by blocking ovulation and thickening the cervical mucus, which prevents sperm from entering the uterus. OGBYNs tell me that if oral contraceptives did block the implementation of a viable embryo, we would expect to see large numbers of ectopic pregnancies with women on the pill – and that is simply not happening.

A report from the Committee on Health Care for Underserved Women that was provided to my office by the American College of Obstetricians and Gynecologists says clearly that none of the current forms of the pill that are available are abortifacients. The current label on birth control pills says that it may prevent implantation of a viable embryo. ACOG says that this label was written in 1999 and does not reflect current research nor the opinion of the medical community.

I am also hearing from critics of AB 36 that birth control actually increases the number of unplanned pregnancies and abortions in our state and country.

According to a 2018 report from the Centers for Disease Control, unintended pregnancy is the major contributor to induced abortion. "Increasing access to and use of effective contraception can reduce unintended pregnancies and further reduce the number of abortions performed in the United States," the report states.

Data from the Guttmacher Institute also shows that from 2008 to 2014, the steep drop in unintended pregnancies — including births and abortions— was likely driven by improved contraceptive use. The U.S. abortion rate decreased 25 percent between 2008 and 2014, while the percentage of unplanned pregnancies that are terminated by abortion, about 40 percent of unplanned pregnancies, has remained unchanged.

The evidence shows that increased contraceptive access played a larger role in reducing the number of abortions than new abortion restrictions. While I support the other pro-life bills being heard today, this bill will have a far greater impact on reducing the number of abortions in Wisconsin than any of them.

I would also like to point out that making birth control available with a prescription from a pharmacist is gaining popularity across the country.

There are currently 23 states that allow women to get their birth control prescriptions from a pharmacy. Washington, D.C., does as well. Several other states are currently considering similar legislative proposals. That number is up from 15 when I first introduced this bill just two years ago. This is not a Republican or Democratic issue. Most of the states to recently enact this legislation have been red states. Already this year, North Carolina, Arkansas, Arizona, Illinois and Nevada have passed this legislation.

Oregon was the first state to pass the pharmacist/birth control law and the results so far have been very encouraging. According to research conducted by Oregon State University, Oregon prevented more than 50 unintended pregnancies and saved an estimated $1.6 million in

associated taxpayer costs in the first two years the law went into effect. Knowing that 40 percent of unplanned pregnancies end in abortion, this means 20 less abortions occurred.

As you can see, we are proposing AB 36 to give women more choices with their reproductive healthcare, decrease the number of unplanned pregnancies and abortions in our state, save taxpayer dollars and reduce generational poverty.

I respect the position of those who morally oppose birth control, but we must not allow a small group to impose their morality onto others. We should not be putting up artificial barriers that prevent increased access to birth control – especially when there is no medical basis to do so.

I want to thank you for taking the time to listen to my testimony, and I hope you consider supporting AB 36. I am also extremely appreciate of all the work that my co-authors, Sen. Felzkowski and Rep. Magnafici, and their staff put into this bill. I am now happy to answer any questions if you have them.

STATE SENATOR KATHY BERNIER
TWENTY-THIRD SENATE DISTRICT

State Capitol • P.O. Box 7882 • Madison, WI 53707
Office: (608) 266-7511 • Toll Free: (888) 437-9436
Sen.Bernier@legis.wi.gov • www.SenatorBernier.com

From: **Senator Kathy Bernier**

To: **Assembly Committee on Health**

Re: **Testimony on Assembly Bill 36**
Relating to: permitting pharmacists to prescribe certain contraceptives, extending the time limit for emergency rule procedures, providing an exemption from emergency rule procedures, granting rule-making authority, and providing a penalty.

Date: **October 7, 2021**

Thank you Chairman Sanfelippo and committee members for hearing Assembly Bill 36 today. Easy access to prescription medication is essential for everyone. However, for many Wisconsin women, getting and maintaining a prescription for birth control can be a major challenge.

To get a prescription for birth control, Wisconsin women must start by making an appointment with a physician or advanced practice nurse. As you all know from experience, seeing a doctor is not only expensive, but just getting an appointment can require waiting weeks for an opening. These challenges are magnified for women in rural areas, who not only wait weeks for an appointment, but often must travel long distances to reach a doctor. Unfortunately, most insurance and health care protocols make getting a prescription renewed or starting medication again after a break just as difficult.

At a time when the US is suffering from a nationwide doctor shortage, the American Medical Association reports that 30% of Wisconsin counties do not have an OB/GYN. This limited access to physicians can result in women going without their birth control medication for a period of time, which can increase the risk of unplanned pregnancy.

However, according to a Pew Research study, 93% of all Americans live within five miles of a pharmacy. AB 36 takes advantage of the widespread availability of pharmacies by allowing women who are 18 or older to receive a prescription for hormonal birth control directly from a pharmacist. AB 36 is modeled after laws in 13 other jurisdictions and would require the pharmacy examining board, after consultation with the Medical Examining Board, the Board of Nursing and the Department of Health Services to establish standard procedures for pharmacists to prescribe birth control for those 18 and older. The bill requires a self-assessment questionnaire, modeled after guidelines established by the American Congress of Gynecologists and a blood pressure screening to ensure that the medication is safe for the patient. The pharmacist would also be required to send a report to the patient's primary care provider.

This legislation is supported by the Wisconsin arm of the American College of Obstetricians and Gynecologists, the Wisconsin Nurses Association, and the Pharmacy Society of Wisconsin.

It is also important to note that unintended pregnancy is the number one reason women seek an induced abortion. Allowing easier access to contraceptives can reduce the number of unplanned pregnancies and thereby reduce the number of abortions in Wisconsin.

Assembly Bill 36 is an opportunity to remove obstacles that keep Wisconsin women from having access to reliable birth control. Please vote to recommend passage of Assembly Bill 36 and help make the lives of women across Wisconsin a little easier.

MARY FELZKOWSKI
STATE SENATOR • 12TH SENATE DISTRICT

Testimony on Assembly Bill 36
Assembly Committee on Health
Senator Mary Felzkowski
12th Senate District
October 7, 2021

Good morning Chairman Sanfelippo and Committee Members,

Thank you for taking the time to hear testimony on Assembly Bill 36, which would allow pharmacists to prescribe oral birth control in Wisconsin.

As you just heard from my co-authors, Representative Kitchens and Senator Bernier, this bill will expand access to a safe and commonly used method of birth control that many women across our state use and benefit from.

In order to get a prescription for birth control now, women must go and make an appointment with a physician or an advanced practice nurse. Those of us in rural areas know that these appointments are not easy to make. The shortage we are facing with rural healthcare providers extends to OB/GYNs and in fact, the American Medical Association estimates that 30% of Wisconsin counties do not have a single practicing OB/GYN. To see any physician and obtain a prescription, a woman in rural Wisconsin is faced with transportation costs and time constraints. This is an artificial barrier that we need to remove. The government should not play the role of gatekeeper in preventing women from accessing this medical tool.

One of the ways we can move forward on addressing the issue of access is to follow in the footsteps of the 23 states that have already passed this and allow pharmacists the authority to prescribe birth control. The Pew Research Center says that 93% of Americans live within 5 miles of a pharmacy. I can tell you that that reality is certainly reflected in my district and throughout the Northwoods.

As Representative Kitchens made clear, there is no medical reason that oral contraceptives need to be prescribed by a physician and OB/GYNs support making birth control available without a prescription at all. The government needs to remove the artificial red tape we have in place and allow women to access this medication without jumping through hoops.

Thank you for your time and consideration and I look forward to your questions.

Capitol Office: P.O. Box 7882 • Madison, WI 53707-7882 • (608) 266-2509 • **Toll-Free:** (800) 334-8775
Cell: (715) 966-3366 • Sen.Felzkowski@legis.wi.gov

To: Representative Joe Sanfelippo

Members, Assembly Committee on Health

From: Kassandra Bartelme, Pharm.D., BCACP

Associate Professor of Pharmacy Practice

Ambulatory Care Pharmacist

Date: October 4, 2021

Subject: Testimony in Support of Assembly Bill 36

Representative Joe Sanfelippo and members of the Committee, thank you very much for allowing me to provide testimony in favor of Assembly Bill 36. My name is Kassandra Bartelme and I am a faculty member at a School of Pharmacy and ambulatory care pharmacist. I teach women's health pharmacotherapy topics to pharmacy students, including contraception (4 hours of instruction on contraception). I also teach contraception to physician assistant students (2 hours of instruction on contraception).

Pregnancy prevention is a public health concern as 45% of all pregnancies nationwide are unintentional, according to the Centers for Disease Control or Prevention (CDC).[1] In Wisconsin, 46% (42,000) of all pregnancies are unintended.[2] Of these unintended pregnancies in Wisconsin, 65% resulted in births, 21% in abortions, and 14% in miscarriages.[2]

Unintended pregnancies can have significant negative impact on women, their families, and society, including social and economic difficulties. It is worth noting that women who are economically disadvantaged are affected by unintended pregnancies and its consequences at a significantly higher rate than other women.[2] Specifically, in 2011, the pregnancy rate of women in the U.S. with incomes lower than the federal poverty level was 112 per 1,000 women compared to just 20 per 1,000 in women with incomes more than 200% the poverty level.[2]

Of the two-thirds of women in our country who are at risk of unintended pregnancy (that is, they are able to get pregnant), those who use contraceptives account for only 5% of all unintended pregnancies.[2] Therefore, the vast majority of unintended pregnancies are in women who are not using contraception or use them inconsistently. Women who have access to and use contraception are not the women getting pregnant unintentionally.

AB 36 proposes that pharmacists be allowed to prescribe and dispense hormonal contraceptive patches and self-administered oral hormonal contraceptives to a person who is at least 18 years of age. Pharmacists are highly educated professionals that have the potential to increase access to contraception, therefore decreasing unintentional pregnancies and saving an untold amount of money in our healthcare system. Pharmacist-prescribed hormonal contraception is evidence-based and has been studied to show feasibility and safety. For example, one study of 26 community pharmacists in Seattle who prescribed hormonal contraceptives to 195 patients found that 92.6% were still using the contraception at 1 month, 80.3% at 6 months, and 70% at 12 months.[3] Patients appreciated the convenience related to pharmacist accessibility. Additionally, 97.7% of patients were satisfied or very satisfied with their experience and reported it was convenient or very convenient to obtain hormonal contraception from a pharmacist compared to another provider. Upwards of 96.6% felt comfortable asking the pharmacist about their prescription or any other questions they have. This study shows patients were accepting and satisfied with obtaining a contraceptive prescription from a pharmacist.

The primary mechanism of action of the contraceptive pill and patch is to prevent ovulation.[4] These contraceptives are not abortifacients. They so reliably prevent ovulation that, when taken correctly, the

likelihood of fertilization is quite low.[4] A secondary mechanism by which these medications prevent pregnancy is by altering the cervical mucus resulting in an inhospitable environment for sperm and preventing sperm penetration.[4] Therefore, even if ovulation occurred, it is unlikely sperm would be able to reach the egg to fertilize it. Additionally, the pill and patch may affect the endometrial lining, such as making it thinner. This may result in a lighter period for some women. There is insufficient evidence to demonstrate that this change could or would actually prevent implantation.[4]

A hormonal contraceptive pill and patch can be prescribed without a physical exam or other tests, besides a blood pressure assessment, per the American College of Obstetricians and Gynecologists (ACOG) and the CDC's U.S. Selected Practice Recommendations for Contraceptive Use, 2016.[5,6] ACOG further states a blood pressure obtained in a non-clinical setting is acceptable. Any other tests or examinations, *including a pelvic exam, do not contribute substantially to safe and effective use of these contraceptives.* Additionally, ACOG and CDC state no routine follow-up is required after initiation of combined hormonal contraception.[5,6] Pharmacists are trained to perform blood pressure assessments. Pharmacists are also trained to educate patients on how and when to take medications and what to monitor for effectiveness and safety (e.g., side effects). Pharmacists are easily accessible during many, if not all, hours of the day for questions or problems related to their medications. As the prescriber, the pharmacist would be able to easily adjust a patient's contraception prescription if side effects occur, such as switching to a pill with a different hormone balance. Pharmacists are qualified to use patients' responses to a questionnaire to determine their eligibility for contraception using the CDC's Medical Eligibility Criteria for Contraceptive Use, 2016.[7]

My position at my university includes practicing as a pharmacist one and one-half days per week. I am an ambulatory care pharmacist and I work in a cardiology clinic alongside physicians, nurse practitioners, registered nurses, and other health care providers. I practice under a collaborative practice agreement that covers several diseases states, such as hypertension, hyperlipidemia, smoking cessation, asthma/COPD, and anticoagulation. My role in the cardiology clinic is to manage patients who take warfarin (Coumadin) which is a blood thinning medication taken to prevent clots and strokes. Our pharmacist-run anticoagulation clinic manages over 500 patients. Some patients make an appointment with me for an INR (International Normalized Ratio) which is a blood test that measures how thin their blood is. I perform the point-of-care finger stick test. Other patients go to a nearby clinic to have it done or via in-home services and we provide telephonic services to them. I adjust each patient's warfarin dose based on their INR result without consulting a physician. The goal is to keep a patient's INR between 2-3 or 2.5-3.5 depending on the reason for the medication. This means the patient's blood is thinner than someone who is not taking warfarin (whose INR would be 1 or 1.1). Warfarin is a high-alert medication per the Institute for Safe Medication Practices.[8] This means it bears a heightened risk of causing significant patient harm when they are used in error. Consequences of errors with high-alert medications are more devastating to patients. Warfarin has a high risk of causing bleeding if the INR gets too high and the risk of clots or strokes is higher in these patients if the INR is too low. The INR goal range is the sweet spot between those two risks and it can be challenging to keep the INR within that goal range. There are many food and drug interactions with warfarin that can cause changes in a patient's INR. The contraceptive pill and patch are not listed as high-alert medications. If the physicians I work with are comfortable with me, a pharmacist, dosing warfarin and other high-alert medications such as insulin, there is no reason why a pharmacist couldn't manage and prescribe contraceptives. Pharmacists managing anticoagulation is quite common and a simple Google search will reveal there are many pharmacist-managed anticoagulation clinics nationwide.

Pharmacist-prescribed contraception may help fill a gap caused by a shortage of primary care physicians and OB-GYN physicians in Wisconsin. According to the Wisconsin Council on Medical Education and Workforce 2018 Healthcare Workforce Report, the majority (82.5%) of Wisconsin's total physicians are in metropolitan areas, yet only 71% of Wisconsin's population is located in those areas.[9] Less than 10% of physicians practice in rural areas, yet nearly 1/5th of the population lives in rural areas of the state. The

primary care physician workforce is projected to increase by 3.8% but nearly 40% are expected to retire by 2035, causing a deficit of primary care physicians in the state.[9] The rural areas are likely to be hit the hardest. Additionally, there is a shortage of OB-GYN physicians in our state, and 27 of Wisconsin's 72 counties don't even have an OB-GYN.[10] Many rural areas have a pharmacy at which pharmacists are more easily accessible than primary care physicians. In fact, about 90% of Americans live within five miles of a pharmacy.[11] This means patients who have trouble accessing a primary care physician or an OB-GYN due to location or time to get an appointment would be able to obtain contraception at their local pharmacy, increasing access and potentially decreasing the number of unintentional pregnancies. A study in Oregon showed their pharmacists prescribed contraception to a total of 367 Medicaid patients. Of those, 73.8% had no history of contraception prescriptions in the previous 30 days and 61.5% had no history in the previous 180 days, indicating that these patients were initiating hormonal contraceptive care in the pharmacy.[12] Patients who have not used contraception in the recent past or ever are seeking contraception from a pharmacist.

Unintended pregnancies are also costly to state and federal governments. In 2010, $21 billion was spent by state and federal governments nationwide. In Wisconsin, 62% of unplanned births were publically funded and, in 2010, $313.5 million of federal and state funds (42% of that coming from the state) were spent on unintended pregnancies. The public costs were $286 per woman aged 15 – 44 in Wisconsin.[2] In 2010, publicly funded family planning services provided by safety-net health centers in Wisconsin helped save the federal and state governments $171.5 million.[2] A research study in Oregon demonstrated their policy allowing pharmacists to prescribe contraception averted an estimated 51 unintended pregnancies among their Medicaid population and saved $1.6 million dollars.[13] Imagine what pharmacists could do in Wisconsin!

A pharmacist prescriber is the key to increasing patient access to contraception resulting in potentially decreased unintentional pregnancies and elective abortions and reduced costs for federal and state governments. It is my professional judgement that pharmacists are highly qualified to prescribe safe and effective medications like the oral contraceptive pill and patch (and other self-administered contraceptives).

Thank you again for the opportunity to provide testimony in favor of AB 36.

References:

1. Unintended Pregnancy Prevention. Center for Disease Control and Prevention. https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/index.htm. Page last reviewed: 12 September 2019. Accessed 4 October 2021.
2. State Facts About Unintended Pregnancy: Wisconsin. Guttmacher Institute. 2014. https://www.guttmacher.org/sites/default/files/factsheet/wi_5.pdf. Accessed 4 October 2021.
3. Gardner JS, Miller L, Downing DF, Le S, Blough D, Shotorbani S. Pharmacist prescribing of hormonal contraceptives: Results of the Direct Access Study. *J Am Pharm Assoc*. 2008;48:212–221.
4. Rivera R, Yacobson I, Grimes D. The mechanism of action of hormonal contraceptives and intrauterine contraceptive devices. Am J Obstet Gynecol. 1999;181:1263-9.
5. Lichtmacher A, Adams M, Berga SL, Davis AJ, Edelson MI, Jamshidi RM, Lehman RA, Peipert JF, Perlmutter JF, Richter HE, Walters MD, Witkop CT, eds. Guidelines for Women's Health Care: A Resource Manual. 4th Ed. Washington DC: American College of Obstetricians and Gynecologists; 2014.
6. Curtis KM, Jatlaoui TC, Tepper NK, Zapata LB, Horton LG, Jamieson DJ, Whiteman MK. U.S. Select Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm Rep. 2016;65(4):1-66. https://www.cdc.gov/mmwr/volumes/65/rr/rr6504a1.htm?s_cid=rr6504a1_w.

7. Curtis KM, Tepper NK, Jatlaoui TC, Berry-Bibee E, Horton LG, Zapata LB, Simmons KB, Pagano HP, Jamieson DJ, Whiteman MK. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. MMWR Recomm Rep. 2016;65(4):1-104. https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html.
8. High-alert Medications in Community/Ambulatory Settings. Institute for Safe Medication Practices. 30 Sept 2021. https://www.ismp.org/recommendations/high-alert-medications-community-ambulatory-list. Accessed 4 October 2021.
9. Mapping Our Way to Success: Wisconsin's Physician Workforce. 2018 WCMEW Healthcare Workforce Report. Wisconsin Council on Medical Education and Workforce. 2018. https://static1.squarespace.com/static/5a3ac16af14aa15aede6d0ed/t/5b48b65faa4a997984be0b1c/1531491941742/WCMEW+2018+Workforce+Report.pdf. Accessed 4 October 2021.
10. Wisconsin 2019 Health Care Workforce Report. Wisconsin Hospital Association. 2019. https://www.wha.org/WisconsinHospitalAssociation/media/WHA-Reports/2019-WHA-Workforce-Report.pdf. Accessed 4 October 2021.
11. Eder R, Dombach T., eds. By The Numbers: How community pharmacists measure up. *RxImpact*. 2015;4:8-9.
12. Anderson L, Hartung DM, Middleton L, Rodriguez MI. Pharmacist Provision of Hormonal Contraception in the Oregon Medicaid Population. Obstet Gynecol. 2019;133:1231-1237.
13. Rodriguez MI, Hersh A, Anderson LB, Hartung DM, Edelman AB. Association of Pharmacist Prescription of Hormonal Contraception with Unintended Pregnancies and Medicaid Costs. Obstet Gynecol. 2019;133:1238–46.

ACOG
The American College of Obstetricians and Gynecologists
Wisconsin Section

To: Assembly Committee on Health
From: American College of Obstetricians and Gynecologists – Wisconsin Section
Kristin Lyerly, MD, MPH, FACOG
Date: October 7, 2021
Re: Assembly Bill 36

Chairman Sanfelippo and members of the Committee, I am here today to testify in support of Assembly Bill 36.

I am a specialist in general obstetrics and gynecology from Green Bay. I am also a Fellow of the American College of Obstetricians and Gynecologists, or ACOG, which represents 60,000 OB/GYNs throughout the U.S. as well as internationally. I am a Wisconsinite by birth and a proud graduate of the University of Wisconsin School of Medicine and Public Health. On a personal note, I am the mom of four sons, ages 13 to 22, and I have a special interest in ensuring that women and families in rural Wisconsin have access to quality, evidence based medical care.

Nearly all U.S. women who have ever had sexual intercourse have used some form of contraception at some point during their reproductive lives. ACOG has long supported over-the-counter access to oral contraceptives with no age restrictions, and recently expanded its recommendation to include vaginal rings, the contraceptive patch, and depot medroxyprogesterone acetate injections, also as "the depo shot". But only the U.S. Food and Drug Administration (the FDA) can confer over-the-counter status for these medications. Recognizing that women need more options to manage their reproductive health, ACOG's recommendation includes support for pharmacist provided contraception, identifying this as a necessary intermediate step to increase access to hormonal contraception.

Facts are important when discussing healthcare. Lack of knowledge, misperceptions, and exaggerated concerns about the safety of contraceptive methods are major barriers to contraceptive use. So let's examine the facts.

Blood clots, or venous thromboembolism, are one of the most commonly cited safety concerns. The risk of blood clots with the typical "combined" estrogen/progestin pill is half the risk of blood clots in pregnancy and only 1/10 of the risk during the postpartum period. The risk for progestin-only methods, including pills and shots, is considered minimal at worst. Numerous studies have demonstrated that women are capable of self-screening for venous thromboembolism risk. In fact, with the use of a validated questionnaire and a blood pressure check, women who choose to get their contraception from a pharmacist will receive screening similar to what I would offer prior to writing a prescription during an office visit.

Concern has been raised that contraceptives are a Class I carcinogen. This is technically true. Depending upon personal risk factors, some women who choose to use hormonal contraception do have a slightly higher risk of breast cancer. Class I carcinogens, by definition, can cause cancer in humans. Some of our favorite Class I carcinogens include smoked meat, alcoholic beverages, and sunshine. The bottom line is this: for the general population, the risk of breast cancer related to the use of hormonal contraception is low.

Efficacy, how well these methods of birth control work, has also been called into question. The data here is very clear: with *typical* use, these contraceptive methods are greater than 90% effective, and with *perfect* use, greater than 99% effective. In contrast, one in four women who use natural family planning, which is another option that I discuss with my patients, will experience an unintended pregnancy. Hormonal contraception is effective in preventing pregnancy.

The mechanism of action for these contraceptive methods has also been challenged. To be clear, no FDA-approved contraceptive methods are abortifacients. By definition, an abortifacient refers to the termination of a

pregnancy. In contrast, these contraceptives either prevent fertilization or implantation. Remember, 50% of fertilized eggs naturally fail to implant.

The benefits of contraception are widely recognized and include improved health and wellbeing, reduced global maternal mortality, optimal pregnancy spacing for maternal and child health, increased female engagement in the work force, and economic self-sufficiency for women. Additionally, non-contraceptive benefits include decreased bleeding and pain with menstrual periods, which keeps women and girls engaged in society, in school and at work, as well as reduced risk of gynecologic disorders, including a decreased risk of cancer, primarily endometrial and ovarian. Universal coverage of contraceptives is cost effective. Increasing access to contraceptives will save money. And, importantly, the most effective way to reduce abortion rates, something we would all like to see, is to prevent unintended pregnancy by improving access to consistent, effective, and affordable contraception.

Still, barriers prevent women from obtaining contraceptives and using them effectively and consistently. Barriers to access are one preventable reason, that we can address today, for inconsistent or nonuse of contraception. The requirement for a prescription can be an obstacle for some contraceptive users. One national survey of 1,385 women reported that, among the 68% of individuals who had ever tried to obtain a prescription for hormonal contraception, nearly a third had problems accessing the initial prescription or refills. These obstacles included cost barriers or lack of insurance; challenges in obtaining an appointment or getting to a clinic; the health care provider requiring a clinic visit; and not having a regular physician or clinic.
1

Pharmacist provided contraception will improve availability, but it should not be at the expense of affordability. Insurance coverage and other financial support for contraception must still apply. Legislation must also protect women from new out-of-pocket costs and ensure that contraceptives dispensed by pharmacists are covered by insurance. It is critical that women are able to afford pharmacist provided contraception.

It is critical that access to pharmacist provided contraception includes access to ALL hormonal contraception - pills, vaginal rings, the patch, and depo shots.

And, because teens have the highest unintended pregnancy rate in the US, it is critical that access to pharmacist provided contraception is not limited by age restrictions.

My colleagues and I, representing our patients - your constituents - couldn't be more clear. All women should have unhindered and affordable access to all FDA approved contraceptives. Chairman Sanfilippo and members, Assembly Bill 36 is your opportunity to remove barriers for women who want to manage their reproductive health with hormonal contraception. Thank you for your time, and I would very much enjoy the opportunity to address your questions.

Landau SC, Tapias MP, McGhee BT. Birth control within reach: a national survey on women's attitudes toward and interest in pharmacy access to hormonal contraception. Contraception 2006;74:463-70;

Grindlay K, Burns B, Grossman D. Prescription requirements and over-the-counter access to oral contraceptives: a global review. Contraception 2013;88:91-6;

Frost JJ, Singh S, Finer LB. U.S. women's one-year contraceptive use patterns, 2004. Perspect Sex Reprod Health 2007;39:48-55;

Grindlay K, Grossman D. Prescription birth control access among U.S. women at risk of unintended pregnancy. J Womens Health (Larchmt) 2016;25:249-54.

Testimony in Opposition to Assembly Bill 36: permitting pharmacists to prescribe certain contraceptives
Assembly Committee on Health
By Matt Sande, Director of Legislation

October 7, 2021

Good morning, Chairman Sanfelippo and Committee members. My name is Matt Sande and I serve as director of legislation for Pro-Life Wisconsin. Thank you for this opportunity to express our opposition to Assembly Bill (AB) 36, legislation permitting pharmacists to prescribe and dispense hormonal contraceptive patches and self-administered oral hormonal contraceptives to persons who are at least 18 years of age.

Studies demonstrate that the bill authors' means to achieving lower unplanned pregnancies (easy contraceptive access and use) is unworkable. A significant percentage of unintended pregnancies are in women using contraceptives, generally over 40% and in some studies up to 68%.

According to a March 2017 Guttmacher Institute study*, "A substantial proportion of unintended pregnancies occur despite women's and their partners' use of contraceptives. In 2001, some 48% of women experiencing an unintended pregnancy had been using a method in the month of conception." In the same study Guttmacher also reported that "about half of pregnancies terminated by induced abortions in 2008 occurred during use of contraceptives." Clearly, contraceptive use is not preventing unplanned pregnancies.

*(Perspectives on Sexual and Reproductive Health, Guttmacher Institute, Volume 49, Issue 1, March 2017, Pages 7-16, *Contraceptive Failure in the United States: Estimates from the 2006-2010 National Survey of Family Growth*)

A December 2015 study** out of Canada noted that "Imperfect contraceptive adherence was estimated to account for 124,024 of the 180,733 UPs [unplanned pregnancies] that occur annually in women age 18–44 years (Table 5)." That equates to over 68% of all unplanned pregnancies (18-44 years) in the study being due to imperfect contraceptive use. So you can give them the pills, but faulty or incorrect use makes them ineffective in reducing unplanned pregnancies.

**(Journal of Obstetrics and Gynaecology Canada, December 2015, Volume 37, Issue 12, Pages 1086–1097, *The Cost of Unintended Pregnancies in Canada: Estimating Direct Cost, Role of Imperfect Adherence, and the Potential Impact of Increased Use of Long-Acting Reversible Contraceptives*)

At the core of our opposition to AB 36 is the abortifacient effect of hormonal contraceptives. It is a medical fact that the morning-after pill (a high dosage of the birth control pill) and most if not all hormonal birth control drugs and devices including the intrauterine device (IUD), Depo Provera, the Patch, and the Pill can act to terminate a pregnancy by chemically

altering the lining of the uterus (endometrium) so that a newly conceived child (human embryo) is unable to implant in the womb, thus starving and dying. This mechanism of action is termed a pre-implantation chemical abortion.

LO/OVRAL-28 is a standard birth control pill manufactured by Wyeth Laboratories. The Physicians' Desk Reference indicates that it can work to prevent a fertilized egg (a human embryo) from implanting in the uterine wall:

LO/OVRAL®-28, a standard birth control pill. Combination oral contraceptives act by suppression of gonadotropins. Although the primary mechanism of this action is inhibition of ovulation, other alterations include ***changes in the*** *cervical mucus (which increase the difficulty of sperm entry into the uterus) and the* ***endometrium (which reduce the likelihood of implantation)*** *(Physicians' Desk Reference (PDR). 56 ed. Montvale, NJ: Thompson PDR; 2002. 3533).*

WebMD also describes the pharmacological action of LO/OVRAL-28:

This combination hormone medication is used to prevent pregnancy. It contains 2 hormones: a progestin and an estrogen. It works mainly by preventing the release of an egg (ovulation) during your menstrual cycle. It also makes vaginal fluid thicker to help prevent sperm from reaching an egg (fertilization) and ***changes the lining of the uterus (womb) to prevent attachment of a fertilized egg. If a fertilized egg does not attach to the uterus, it passes out of the body.***

The United Kingdom's National Health Service (NHS) website describes the contraceptive patch's mechanism of action:

The patch releases a daily dose of hormones through the skin into the bloodstream to prevent pregnancy. It contains the same hormones as the combined pill – oestrogen and progestogen – and works in the same way by preventing the release of an egg each month (ovulation). It also thickens cervical mucus, which makes it more difficult for sperm to move through the cervix, ***and thins the womb lining so a fertilised egg is less likely to be able to implant itself.***

WebMD also describes the pharmacological action of the transdermal patch:

The patch blocks conception by delivering the hormones estrogen and progestin through the skin into your bloodstream. The hormones keep your ovaries from releasing an egg, thicken the cervical mucus to deter the swimming sperm, and ***make it harder for any fertilized egg to implant inside your womb.***

In the January 2019 Linacre Quarterly, a peer-reviewed publication of the Catholic Medical Association, medical researchers published a study*** entitled "Systematic Review of Ovarian Activity and Potential for Embryo Formation and Loss during the Use of Hormonal Contraception." The abstract of the study states, "...follicular ruptures and egg release with

subsequent low progesterone output have been documented in women using hormonal contraception...(this) suboptimal luteal progesterone production may be more likely than previously acknowledged, which may contribute to embryo loss. This information should be included in informed consent for women who are considering the use of hormonal contraception." In other words, the abnormally low progesterone production while taking hormonal contraceptives can lead to early embryo loss and women should be informed of this possibility.

***(The Linacre Quarterly, January 3, 2019, *Systematic Review of Ovarian Activity and Potential for Embryo Formation and Loss during the Use of Hormonal Contraception*)

When the Pill was first introduced it contained high estrogen levels with severe side effects. Today's pills contain dramatically lower hormone doses which allow for breakthrough ovulation, embryo formation in the fallopian tube, and then blockage of implantation of the embryo in the uterine wall. While admitting that hormonal birth control can inhibit the implantation of a fertilized egg, the makers of these drugs claim that they do not cause an abortion. For example, they argue that hormonal contraceptives "prevent pregnancy" or "will not affect an existing pregnancy." However, they intentionally define the term "pregnancy" as implantation of a fertilized egg in the lining of a woman's uterus, as opposed to "pregnancy" beginning at fertilization.

Whether one understands "pregnancy" as beginning at implantation or fertilization, the heart of the matter is when human life begins. Embryological science has clearly determined that human life begins at fertilization - the fusion of an egg and sperm immediately resulting in a new, genetically distinct human being. This is not a subjective opinion, but an irrefutable, objective scientific fact. Accordingly, any artificial action that works to destroy a human embryo is abortifacient in nature.

The authors contend that hormonal contraceptives have no "potentially harmful side effects that require a physician's oversight." We strongly disagree. **Hormonal contraceptives have been proven dangerous to women's health.** The World Health Organization has classified combined hormonal contraceptives as Group 1 carcinogens (carcinogenic to humans.) The United Nation's International Agency on Research of Cancer (IARC) reported in their Monograph 91 that estrogen-progestin combination drugs (the Pill) were a Group 1 carcinogen for breast, cervical and liver cancers. Users of the Pill have an increased risk of blood clotting and ectopic pregnancy, both of which can be fatal. Lawsuits have been filed blaming the Patch for several deaths due to blood clots, heart attacks and strokes. The Food and Drug Administration has cautioned that the Patch carries a higher risk of blood clots than the birth control pill.

Pro-Life Wisconsin is opposed to all forms of artificial contraception, both hormonal and barrier methods. When you delink or decouple sexual intercourse and procreation through

contraceptives, and a baby is conceived (as often happens when using the Pill or a condom), he or she is most often not welcomed as a blessing but rather considered a problem, a mistake. All problems have a solution, the abortion temptation sets in, and abortion is then used as a form of birth control. This is what we call the contraceptive mentality.

Alternatively, Pro-Life Wisconsin supports natural methods of achieving or avoiding pregnancy, or spacing children, that are organic, open to life, highly effective, and totally self-giving. We recommend natural family planning methods that pinpoint the fertile and infertile periods of a woman's cycle.

For the above reasons, we oppose legislation in whatever form that makes hormonal contraceptives more easily accessible or widely available. We urge you to NOT recommend AB 36 for passage.

Thank you for your consideration, and I am happy to answer any questions committee members may have for me. I am also happy to email any of the studies referenced in my testimony to committee members.

1212 New York Ave. NW
Suite 900
Washington, D.C. 20005
202-525-5717

Free Markets. Real Solutions.
www.rstreet.org

Testimony from:
Caroline Kitchens, Director of Government Affairs, R Street Institute

Regarding Assembly Bill 36, "An Act to amend 450.095 (title) and 450.095 (3); and to create 49.46 (2) (bg), 450.01 (16) (L), 450.095 (1) (ag) and (ar) and 450.095 (2m) of the statutes; Relating to: permitting pharmacists to prescribe certain contraceptives, extending the time limit for emergency rule procedures, providing an exemption from emergency rule procedures, granting rule-making authority, and providing a penalty. (FE)"

Oct. 7, 2021

Assembly Committee on Health

Chairman Sanfelippo and members of the Committee,

Thank you for the opportunity to testify today. My name is Caroline Kitchens, and I am director of government affairs at the R Street Institute. R Street is a nonprofit, nonpartisan public policy research organization based in Washington, D.C., whose mission is to engage in policy research and outreach to promote free markets and limited, effective government. I appreciate the opportunity to offer insight on birth control delivery in Wisconsin and the pharmacy access model.

In Wisconsin and many U.S. states, women are required to make routine visits to a doctor or advanced practice nurse to get a prescription for hormonal contraception.[1] This is unnecessary from a medical standpoint and puts an undue burden on Wisconsin women, families and taxpayers. If enacted, Assembly Bill 36 would allow Wisconsin to join a growing number of states who have safely expanded access to birth control and given women more autonomy over their reproductive health.

At the R Street Institute, we have worked with a number of state legislatures who have adopted the pharmacy access model, which allows women to obtain a birth control prescription safely and directly from pharmacists. To date, 22 states across the country and political spectrum, including Washington, D.C., have adopted this model. In these states, preliminary evidence shows that the new model has been received favorably and is working effectively to reduce unintended pregnancies and associated public health care expenditures. Currently, there are ongoing legislative efforts to bring pharmacy access to many other states, including Iowa, Illinois, South Carolina and more.[2]

---

[1] "Pharmacist Prescribing of Hormonal Contraceptives," Power to Decide, Sept. 30 2021. https://powertodecide.org/sites/default/files/2021-09/Pharmacist%20Prescribing.pdf.
[2] Ibid.

1212 New York Ave. NW
Suite 900
Washington, D.C. 20005
202-525-5717

Evidence for the pharmacy access model's successes is promising. In Oregon, a study found that 10 percent of all new birth control prescriptions given to Oregon Medicaid enrollees were written by pharmacists. In addition, 74 percent of the women prescribed birth control by pharmacists had no history of birth control prescriptions in the past month.[3] This suggests that the pharmacy access model has been able to reach women who otherwise would not be using hormonal birth control due to the time and money spent accessing a doctor.

Oregon's pharmacy access program has also decreased unintended pregnancies and saved money for taxpayers. A study examining Oregon's program and Medicaid enrollees shows that, over just two years, pharmacists prescribing birth control reduced the publicly funded medical costs associated with unintended pregnancies by $1.6 million and prevented more than 50 unplanned pregnancies.[4] Because 42 percent of unintended pregnancies end in abortion, it is reasonable to conclude that the pharmacy access model reduced abortions in the state as well.[5]

There is longstanding evidence showing that birth control access increases women's workforce participation, reduces public spending, and drives down rates of unintended pregnancy and abortion. Unintended pregnancies are at an all-time low in the United States and in Wisconsin but still represent about 45 percent of all pregnancies. This rate has decreased substantially from 54 percent in 2008.[6] An overall increase in birth control use and the use of more effective methods is credited as the primary reason for this decrease.[7]

---

[3] Maria Rodriguez, et al., "Association of Pharmacist Prescription of Hormonal Contraception with Unintended Pregnancies and Medicaid Costs" *Obstetrics & Gynecology* 133:6 (June 2019) pp. 1238-1246. .https://journals.lww.com/greenjournal/Abstract/2019/06000/Association_of_Pharmacist_Prescription_of_Hormonal.23.aspx.

[4] Lorinda Anderson, et al., "Pharmacist Provision of Hormonal Contraception in the Oregon Medicaid Population," *Obstetrics & Gynecology* 133:6 (June 2019) pp. 1231-1237. https://journals.lww.com/greenjournal/Abstract/2019/06000/Pharmacist_Provision_of_Hormonal_Contraception_in.22.aspx.

[5] "Contraceptive Use in the United States by Demographics," Guttmacher Institute, May 2021. https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states.

[6] Rachel K. Jones and Jenna Jerman, "Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014," *American Journal of Public Health* 107:12 (December 2017) pp. 1904-1909. https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304042.

[7] Laura D. Lindberg, et al., "Changing Patterns of Contraceptive Use and the Decline in Rates of Pregnancy and Birth Among U.S. Adolescents, 2007-2014," *Journal of Adolescent Health*, 63:2 (Aug. 1, 2018), pp. 253-256. https://www.jahonline.org/article/S1054-139X(18)30200-3/fulltext; M.A. Biggs, et al., "Did increasing use of highly effective contraception contribute to declining abortions in Iowa?" *Contraception* 91:2 (Feb. 1, 2015), pp. 167-173. https://www.contraceptionjournal.org/article/S0010-7824(14)00733-1/fulltext.

1212 New York Ave. NW
Suite 900
Washington, D.C. 20005
202-525-5717

Free Markets. Real Solutions.
www.rstreet.org

While the R Street Institute does not take a direct position on abortion, historical data clearly demonstrates that better access to contraception and declining abortion rates have gone hand-in-hand. As mentioned above, 42 percent of unintended pregnancies end in abortion at present, and that has remained constant since 2008. However, from 2008 to 2014, while the percentage of unintended pregnancies that end in abortion remained stable, the overall abortion rate declined by 25 percent. The declining abortion rate is attributable to fewer unintended pregnancies, largely made possible by birth control access.[8]

There is no denying that hormonal birth control is effective. When taken properly, the pill has a failure rate of less than 1 percent. Meanwhile, couples who do not use any method of contraception have an 85 percent chance of getting pregnant within a year.[9] Unnecessary barriers like doctors' visits impede women's ability to access hormonal contraception and use it consistently without interruption. The pharmacy access model reduces these barriers.

Evidence from across the country and around the world has shown that birth control can safely be prescribed without the unnecessary intermediation of a doctor. The United States is outside the norm with its strict regulatory approach: In the vast majority of countries, birth control is available with no prescription at all.[10] Leading medical groups like the American College of Obstetricians and Gynecologists, the American Medical Association and the American Academy of Family Physicians all agree that birth control is appropriate for use without any prescription barrier.[11]

Improved birth control access is tied to many positive outcomes, but the current regulatory environment in Wisconsin needlessly restricts access and limits women's choices. Allowing pharmacists to prescribe hormonal contraception is a proven strategy to expand birth control access and increase

---

[8] "Unintended Pregnancy in the United States," Guttmatcher Institute, January 2019. https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.

[9] "Contraceptive Use in the United States by Demographics," Guttmacher Institute (2021). https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states.

[10] Kate Grindlay, et al., "Prescription requirements and over-the-counter access to oral contraceptives: a global review," *Contraception* 88:1 (Dec. 10, 2012) pp. 91-96. https://pubmed.ncbi.nlm.nih.gov/23352799/.

[11] "Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy," American College of Obstetricians and Gynecologists, *Committee Opinion* No. 642, October 2015 (Reaffirmed 2018). https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Increasing-Access-to-Contraceptive-Implants-and-Intrauterine-Devices-to-Reduce-Unintended-Pregnancy; "Memorial Resolutions Adopted Unanimously," American Medical Association, 2017. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/hod/a17-resolutions.pdf; "Over-the-Counter Oral Contraceptives," American Academy of Family Physicians, 2014. https://www.aafp.org/about/policies/all/otc-oral-contraceptives.html.

1212 New York Ave. NW
Suite 900
Washington, D.C. 20005
202-525-5717

Free Markets. Real Solutions.
www.rstreet.org

women's autonomy over their family planning preferences, while also reducing the public health and taxpayer burdens of unplanned pregnancies.

For these reasons, AB 36 is a significant step toward more sensible regulation and deserves serious consideration.

Respectfully submitted,

Caroline Kitchens
Director of Government Affairs
R Street Institute

WISCONSIN FAMILY ACTION
Marriage|Family|Life|Liberty

PO Box 7486 • Madison WI 53707-7486
608-268-5074 (Madison) • 866-849-2536 (toll-free) • 608-256-3370 (fax)
info@wifamilyaction.org • www.wifamilyaction.org

TESTIMONY IN OPPOSITION TO ASSEMBLY BILL 36
ASSEMBLY COMMITTEE ON HEALTH
THURSDAY, OCTOBER 7, 2021
JULAINE K. APPLING, PRESIDENT

Thank you, Chairman Sanfelippo and committee members, for the opportunity to testify on Assembly Bill 36. Wisconsin Family Action opposes this bill. We acknowledge the stated intent of the authors, but we believe the problems that come with this proposal far outweigh the good intentions.

First, let me clarify our organizational position on contraceptives in general. We do not take a position on whether or not a married couple should use contraception, unless a contraceptive method can result in the destruction of the fertilized egg, which generally happens because a contraceptive drug or device often prevents a fertilized egg from implanting in the uterine wall. We have never promoted contraception for unmarried persons because that position is inconsistent with our belief that what is in the best interest of unmarried individuals is to remain sexually abstinent until marriage and faithful to their spouse when they do marry.

At the outset, I would like to address one of the main arguments posited by this bill's authors. You will hear today that passing this bill will help reduce poverty because it will reduce unwanted pregnancies which come with a public cost in addition to the very real costs in human terms. We acknowledge the public and personal cost of babies born to single moms, but allowing pharmacists to prescribe contraception is not the answer. One of, if not the best, antidotes to poverty is marriage. It certainly is not contraception. If this body is truly interested in reducing poverty in any kind of meaningful way, it will promote the Success Sequence, which is finish school, get a job, marry, and then have children.

Allowing pharmacists to prescribe and dispense contraception, at least to some degree, promotes unmarried individuals engaging in sexual activity. The argument that these individuals will get contraceptives somewhere, and it may as well be from a pharmacist who cannot perform an abortion, rings hollow. Pharmacies often are much more convenient in location and hours than are other places where contraceptives might be obtained, increasing the likelihood that more women will turn to pharmacists for their prescriptions. Should the contraception fail, and studies show it surely does at times, and a woman becomes pregnant, that the woman received the contraception from a pharmacist rather than from an organization that performs abortions will not deter the woman from having an abortion if that is what she is determined to do.

I think it is also important to note that this proposed change in the scope of practice for pharmacists is not about health-care. Contraception is not health care. Contraception is about the personal choices and decisions of individual women, typically made under the advice and guidance of a doctor because of the potency of the pharmaceuticals involved. To talk in terms of this being about women's health care is, at a minimum, disingenuous.

In addition, some contraceptives are known to cause a pre-implantation chemical abortion, as I referenced earlier. Scientifically, we know life begins at conception. Contraceptives that make it impossible for this newly conceived human being to implant in the uterine wall destroy the human being in the earliest stages of development.

Further, we are concerned about the well-being of the individual woman seeking the contraception. The bill provides that the person must complete "a self-assessment questionnaire and undergo a blood pressure screening." Based on this very limited information, most of which is self-reporting, the pharmacist must determine whether it is safe to prescribe a contraceptive for a given individual. The presumption is, of course, that the individual is accurately reporting his/her medical situation historically and currently. Inaccurate medical information could be dangerous, even in some instances fatal.

This same law is in effect in Colorado, and the self-assessment questionnaire that state uses is available online, as is the Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use (copy attached). That chart makes it clear a significant number of medical conditions pose a "theoretical or proven risk" or even an "unacceptable health risk" for contraceptives. If the individual has an undisclosed condition that dictates that contraceptives should not be used and the pharmacist, in good faith, prescribes and dispenses some form of contraception, the individual's health is at a minimum compromised.

Should this burden rest on a pharmacist who is severely limited in what he or she can learn about the real health of the individual seeking the contraception? Blood pressure is only one measure of one's health; it is certainly not something physicians typically rely on in isolation (or even in conjunction with a self-administered assessment) to determine one's overall health or the appropriateness of a certain prescription. Pharmacists cannot do further diagnostic testing or assessments.

Additionally, what is to prevent a woman who has a severe reaction to the prescribed and dispensed contraception from suing the pharmacist and/or the pharmacy? The language of the bill does not address the liability of the pharmacist or the pharmacy, which presumably would have some culpability since the pharmacist is acting in his/her official capacity as an employee of the pharmacy. Last session during a public hearing, a committee member asked a testifying pharmacist about liability. The pharmacist speaking in support of the proposal said, "We don't know about liability." When I followed up with my testimony and addressed this issue, a committee member responded to me by saying, "You know we frequently pass bills where we don't know who is liable." I suggested that perhaps this is not the wisest course of action for the state legislature, particularly in this instance and especially in the ultra-litigious society in which we live.

We also oppose this bill because it puts pharmacists who may have religious or conscience objections to prescribing contraception in general and in particular contraception that is known to be abortifacient, in a difficult position. We currently have no specific statutory protection for the religious or conscience rights of pharmacists. While the bill does not force any pharmacy to take part in this prescription-writing authority, it is safe to say many will. Imagine a pharmacist working for a pharmacy that decides to do this and thereby requires its pharmacists to either write prescriptions for contraception or face disciplinary action, which could even involve dismissal.

For these reasons, we urge this committee to oppose this bill that is not in the best interest of those seeking contraception or in the best interest of the pharmacists.

Thank you for your attention and thoughtful consideration of our position on this proposal.

Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Age		Menarche to <20 yrs:2		Menarche to <20 yrs:2		Menarche to <18 yrs:1		Menarche to <18 yrs:2		Menarche to <18 yrs:1		Menarche to <40 yrs:1	
		≥20 yrs:1		≥20 yrs:1		18-45 yrs:1		18-45 yrs:1		18-45 yrs:1		≥40 yrs:2	
						>45 yrs:1		>45 yrs:2		>45 yrs:1			
Anatomical abnormalities	a) Distorted uterine cavity	4		4									
	b) Other abnormalities	2		2									
Anemias	a) Thalassemia	2		1		1		1		1		1	
	b) Sickle cell disease‡	2		1		1		1		1		2	
	c) Iron-deficiency anemia	2		1		1		1		1		1	
Benign ovarian tumors	(*including cysts*)	1		1		1		1		1		1	
Breast disease	a) Undiagnosed mass	1		2		2*		2*		2*		2*	
	b) Benign breast disease	1		1		1		1		1		1	
	c) Family history of cancer	1		1		1		1		1		1	
	d) Breast cancer‡												
	i) Current	1		4		4		4		4		4	
	ii) Past and no evidence of current disease for 5 years	1		3		3		3		3		3	
Breastfeeding	a) <21 days postpartum					2*		2*		2*		4*	
	b) 21 to <30 days postpartum												
	i) With other risk factors for VTE					2*		2*		2*		3*	
	ii) Without other risk factors for VTE					2*		2*		2*		3*	
	c) 30-42 days postpartum												
	i) With other risk factors for VTE					1*		1*		1*		3*	
	ii) Without other risk factors for VTE					1*		1*		1*		2*	
	d) >42 days postpartum					1*		1*		1*		2*	
Cervical cancer	Awaiting treatment	4	2	4	2	2		2		1		2	
Cervical ectropion		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		1		2		2		2		1		2	
Cirrhosis	a) Mild (*compensated*)	1		1		1		1		1		1	
	b) Severe‡ (*decompensated*)	1		3		3		3		3		4	
Cystic fibrosis‡		1*		1*		1*		2*		1*		1*	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy												
	i) Higher risk for recurrent DVT/PE	1		2		2		2		2		4	
	ii) Lower risk for recurrent DVT/PE	1		2		2		2		2		3	
	b) Acute DVT/PE	2		2		2		2		2		4	
	c) DVT/PE and established anticoagulant therapy for at least 3 months												
	i) Higher risk for recurrent DVT/PE	2		2		2		2		2		4*	
	ii) Lower risk for recurrent DVT/PE	2		2		2		2		2		3*	
	d) Family history (*first-degree relatives*)	1		1		1		1		1		2	
	e) Major surgery												
	i) With prolonged immobilization	1		2		2		2		2		4	
	ii) Without prolonged immobilization	1		1		1		1		1		2	
	f) Minor surgery without immobilization	1		1		1		1		1		1	
Depressive disorders		1*		1*		1*		1*		1*		1*	

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Diabetes	a) History of gestational disease	1		1		1		1		1		1	
	b) Nonvascular disease												
	i) Non-insulin dependent	1		2		2		2		2		2	
	ii) Insulin dependent	1		2		2		2		2		2	
	c) Nephropathy/retinopathy/neuropathy‡	1		2		2		3		2		3/4*	
	d) Other vascular disease or diabetes of >20 years' duration‡	1		2		2		3		2		3/4*	
Dysmenorrhea	Severe	2		1		1		1		1		1	
Endometrial cancer‡		4	2	4	2	1		1		1		1	
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		2		1		1		1		1		1	
Epilepsy‡	(*see also Drug Interactions*)	1		1		1*		1*		1*		1*	
Gallbladder disease	a) Symptomatic												
	i) Treated by cholecystectomy	1		2		2		2		2		2	
	ii) Medically treated	1		2		2		2		2		3	
	iii) Current	1		2		2		2		2		3	
	b) Asymptomatic	1		2		2		2		2		2	
Gestational trophoblastic disease‡	a) Suspected GTD (immediate postevacuation)												
	i) Uterine size first trimester	1*		1*		1*		1*		1*		1*	
	ii) Uterine size second trimester	2*		2*		1*		1*		1*		1*	
	b) Confirmed GTD												
	i) Undetectable/non-pregnant ß-hCG levels	1*	1*	1*	1*	1*		1*		1*		1*	
	ii) Decreasing ß-hCG levels	2*	1*	2*	1*	1*		1*		1*		1*	
	iii) Persistently elevated ß-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*		1*		1*		1*	
	iv) Persistently elevated ß-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	4*	2*	4*	2*	1*		1*		1*		1*	
Headaches	a) Nonmigraine (mild or severe)	1		1		1		1		1		1*	
	b) Migraine												
	i) Without aura (includes menstrual migraine)	1		1		1		1		1		2*	
	ii) With aura	1		1		1		1		1		4*	
History of bariatric surgery‡	a) Restrictive procedures	1		1		1		1		1		1	
	b) Malabsorptive procedures	1		1		1		1		3		COCs: 3 P/R: 1	
History of cholestasis	a) Pregnancy related	1		1		1		1		1		2	
	b) Past COC related	1		2		2		2		2		3	
History of high blood pressure during pregnancy		1		1		1		1		1		2	
History of Pelvic surgery		1		1		1		1		1		1	
HIV	a) High risk for HIV	1*	1*	1*	1*	1		1		1		1	
	b) HIV infection					1*		1*		1*		1*	
	i) Clinically well receiving ARV therapy	1	1	1	1	If on treatment, see Drug Interactions							
	ii) Not clinically well or not receiving ARV therapy‡	2	1	2	1	If on treatment, see Drug Interactions							

Key:

1 No restriction (method can be used)	3 Theoretical or proven risks usually outweigh the advantages
2 Advantages generally outweigh theoretical or proven risks	4 Unacceptable health risk (method not to be used)

Abbreviations: ARV = antiretroviral; C=continuation of contraceptive method; CHC=combined hormonal contraception (pill, patch, and, ring); COC=combined oral contraceptive; Cu-IUD=copper-containing intrauterine device; DMPA = depot medroxyprogesterone acetate; I=initiation of contraceptive method; LNG-IUD=levonorgestrel-releasing intrauterine device; NA=not applicable; POP=progestin-only pill; P/R=patch/ring; SSRI=selective serotonin reuptake inhibitor; ‡ Condition that exposes a woman to increased risk as a result of pregnancy. *Please see the complete guidance for a clarification to this classification: https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm.

Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Hypertension	a) Adequately controlled hypertension	1*		1*		1*		2*		1*		3*	
	b) Elevated blood pressure levels (*properly taken measurements*)												
	i) Systolic 140-159 or diastolic 90-99	1*		1*		1*		2*		1*		3*	
	ii) Systolic ≥160 or diastolic ≥100‡	1*		2*		2*		3*		2*		4*	
	c) Vascular disease	1*		2*		2*		3*		2*		4*	
Inflammatory bowel disease	(*Ulcerative colitis, Crohn's disease*)	1		1		1		2		2		2/3*	
Ischemic heart disease‡	Current and history of	1		2	3	2	3	3		2	3	4	
Known thrombogenic mutations‡		1*		2*		2*		2*		2*		4*	
Liver tumors	a) Benign												
	i) Focal nodular hyperplasia	1		2		2		2		2		2	
	ii) Hepatocellular adenoma‡	1		3		3		3		3		4	
	b) Malignant† (hepatoma)	1		3		3		3		3		4	
Malaria		1		1		1		1		1		1	
Multiple risk factors for atherosclerotic cardiovascular disease	(e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high triglyceride levels)	1		2		2*		3*		2*		3/4*	
Multiple sclerosis	a) With prolonged immobility	1		1		1		2		1		3	
	b) Without prolonged immobility	1		1		1		2		1		1	
Obesity	a) Body mass index (BMI) ≥30 kg/m²	1		1		1		1		1		2	
	b) Menarche to <18 years and BMI ≥ 30 kg/m²	1		1		1		2		1		2	
Ovarian cancer‡		1		1		1		1		1		1	
Parity	a) Nulliparous	2		2		1		1		1		1	
	b) Parous	1		1		1		1		1		1	
Past ectopic pregnancy		1		1		1		1		2		1	
Pelvic inflammatory disease	a) Past												
	i) With subsequent pregnancy	1	1	1	1	1		1		1		1	
	ii) Without subsequent pregnancy	2	2	2	2	1		1		1		1	
	b) Current	4	2*	4	2*	1		1		1		1	
Peripartum cardiomyopathy‡	a) Normal or mildly impaired cardiac function												
	i) <6 months	2		2		1		1		1		4	
	ii) ≥6 months	2		2		1		1		1		3	
	b) Moderately or severely impaired cardiac function	2		2		2		2		2		4	
Postabortion	a) First trimester	1*		1*		1*		1*		1*		1*	
	b) Second trimester	2*		2*		1*		1*		1*		1*	
	c) Immediate postseptic abortion	4		4		1*		1*		1*		1*	
Postpartum (*nonbreastfeeding women*)	a) <21 days					1		1		1		4	
	b) 21 days to 42 days												
	i) With other risk factors for VTE					1		1		1		3*	
	ii) Without other risk factors for VTE					1		1		1		2	
	c) >42 days					1		1		1		1	
Postpartum (*in breastfeeding or non-breastfeeding women, including cesarean delivery*)	a) <10 minutes after delivery of the placenta												
	i) Breastfeeding	1*		2*									
	ii) Nonbreastfeeding	1*		1*									
	b) 10 minutes after delivery of the placenta to <4 weeks	2*		2*									
	c) ≥4 weeks	1*		1*									
	d) Postpartum sepsis	4		4									

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Pregnancy		4*		4*		NA*		NA*		NA*		NA*	
Rheumatoid arthritis	a) On immunosuppressive therapy	2	1	2	1	1		2/3*		1		2	
	b) Not on immunosuppressive therapy	1		1		1		2		1		2	
Schistosomiasis	a) Uncomplicated	1		1		1		1		1		1	
	b) Fibrosis of the liver‡	1		1		1		1		1		1	
Sexually transmitted diseases (STDs)	a) Current purulent cervicitis or chlamydial infection or gonococcal infection	4	2*	4	2*	1		1		1		1	
	b) Vaginitis (*including trichomonas vaginalis and bacterial vaginosis*)	2	2	2	2	1		1		1		1	
	c) Other factors relating to STDs	2*	2	2*	2	1		1		1		1	
Smoking	a) Age <35	1		1		1		1		1		2	
	b) Age ≥35, <15 cigarettes/day	1		1		1		1		1		3	
	c) Age ≥35, ≥15 cigarettes/day	1		1		1		1		1		4	
Solid organ transplantation‡	a) Complicated	3	2	3	2	2		2		2		4	
	b) Uncomplicated	2		2		2		2		2		2*	
Stroke†	History of cerebrovascular accident	1		2		2	3	3		2	3	4	
Superficial venous disorders	a) Varicose veins	1		1		1		1		1		1	
	b) Superficial venous thrombosis (acute or history)	1		1		1		1		1		3*	
Systemic lupus erythematosus‡	a) Positive (or unknown) antiphospholipid antibodies	1*	1*	3*		3*		3*	3*	3*		4*	
	b) Severe thrombocytopenia	3*	2*	2*		2*		3*	2*	2*		2*	
	c) Immunosuppressive therapy	2*	1*	2*		2*		2*	2*	2*		2*	
	d) None of the above	1*	1*	2*		2*		2*	2*	2*		2*	
Thyroid disorders	Simple goiter/ hyperthyroid/hypothyroid	1		1		1		1		1		1	
Tuberculosis‡ (*see also Drug Interactions*)	a) Nonpelvic	1	1	1	1	1*		1*		1*		1*	
	b) Pelvic	4	3	4	3	1*		1*		1*		1*	
Unexplained vaginal bleeding	(suspicious for serious condition) before evaluation	4*	2*	4*	2*	3*		3*		2*		2*	
Uterine fibroids		2		2		1		1		1		1	
Valvular heart disease	a) Uncomplicated	1		1		1		1		1		2	
	b) Complicated‡	1		1		1		1		1		4	
Vaginal bleeding patterns	a) Irregular pattern without heavy bleeding	1		1	1	2		2		2		1	
	b) Heavy or prolonged bleeding	2*		1*	2*	2*		2*		2*		1*	
Viral hepatitis	a) Acute or flare	1		1		1		1		1		3/4*	2
	b) Carrier/Chronic	1		1		1		1		1		1	1
Drug Interactions													
Antiretrovirals used for prevention (PrEP) or treatment of HIV	Fosamprenavir (FPV) All other ARVs are 1 or 2 for all methods.	1/2*	1*	1/2*	1*	2*		2*		2*		3*	
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	1		1		2*		1*		3*		3*	
	b) Lamotrigine	1		1		1		1		1		3*	
Antimicrobial therapy	a) Broad spectrum antibiotics	1		1		1		1		1		1	
	b) Antifungals	1		1		1		1		1		1	
	c) Antiparasitics	1		1		1		1		1		1	
	d) Rifampin or rifabutin therapy	1		1		2*		1*		3*		3*	
SSRIs		1		1		1		1		1		1	
St. John's wort		1		1		2		1		2		2	

Updated in 2020. This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see: https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm Most contraceptive methods do not protect against sexually transmitted diseases (STDs). Consistent and correct use of the male latex condomreduces the risk of STDs and HIV.

CS314239-A

WISCONSIN CATHOLIC MEDICAL GUILDS

Upholding the Principles of the Catholic Faith in the Science and Practice of Medicine

October 7, 2021

To: Members, Assembly Committee on Health

FROM: Elizabeth Anderson, MD, Assistant State Director – Wisconsin Catholic Medical Guilds; President - Madison Catholic Medical Guild

RE: Assembly Bill 36 – permitting pharmacists to prescribe certain contraceptives

Good morning Chairman Sanfelippo and Committee members. My name is Elizabeth Anderson. I am an emergency medicine physician here in Madison. I graduated from the Medical College of Wisconsin in 2005 and completed my residency at Froedtert Hospital in Milwaukee in 2008. I have been an ER physician here in Madison since then. I am also the current president of the Catholic Medical Guild of the Diocese of Madison and the Assistant Director of the Wisconsin Catholic Medical Guilds. I am here today on behalf of the Wisconsin Catholic Medical Guilds which represents the six guilds of the Catholic Medical Association throughout Wisconsin, with more than 100 physician and healthcare provider members.

The Wisconsin Catholic Medical Guilds (WCMG) is opposed to Assembly Bill (AB) 36 and strongly urges you to not pass this bill out of committee.

As you know, AB 36 would allow pharmacists to prescribe either contraceptive patches or oral contraceptives to patients without the input of a medical doctor. WCMG is opposed to this practice for several reasons.

First, the patient-physician relationship is of utmost importance in providing safe, quality healthcare to individuals. This bill would eliminate that relationship, undermining the ongoing necessary healthcare that a patient should have with any prescription medication and any health condition. Primary care physicians have a unique relationship with their patients in which they can provide individualized counseling and recommendations, as well as discuss risks of prescription medications unique to each individual patient. This relationship and individualized care is eliminated if this bill moves forward.

Second, any prescription medication carries risks, which is why they require a prescription. A primary medical doctor has the ability to not only discuss these risks at the time of initial prescription but to monitor for signs/symptoms of these risks. Making contraceptives available, essentially as over-the-counter medications, ignores the significant risks associated with them. The CDC has produced a chart as reference for medical conditions that are affected by contraceptives. As you can see, it is extensive. A pharmacist does not have access to a patient's medical records and so is relying on a questionnaire that may or may not be answered correctly by the patient. I can assure you, that patients frequently do not remember or

691 S. Green Bay Road, #175, Neenah, WI 54956 www.sgmgnew.com *work* 920-725-1040 *cell* 920-716-1451 sgmgnew@gmail.com

understand their medical diagnoses or medications they are taking. Thus, a pharmacist very likely will not get accurate information and therefore cannot adequately assess a patient's risk.

Contraceptives by themselves are medications with significant medical risk. The World Health organization has categorized contraceptives as class 1 carcinogens, meaning they have been proven to cause cancer in humans, including breast, cervical, and liver cancer. Some proponents of this bill quote a study out of Canada claiming a small increase in breast cancer (6.3%) and a "possible" prevention of 57% of endometrial and 29% of ovarian cancer. Use of this study to encourage pharmacist prescribing of contraceptives is faulty for a couple reasons. First, this study estimates the association of oral contraceptives based on a survey of women answering whether or not they used hormonal contraceptives and whether they developed cancer. Clearly this is not the highest level of evidence available. Second, giving a percentage reduction does not account for the incidence of these cancers. The National Cancer Institute lists the incidence of ovarian cancer at 11 per 100,000 whereas the incidence of breast cancer is 127 per 100,000. So, a reduction of 29% of ovarian cancer means 3 less cases per 100,000 whereas an increase in 6% of breast cancer means an increase of 8 cases per 100,000. I would like to point out an alternative, higher level of evidence study done as a meta-analysis that compiled 76 recent studies (from 2000 to 2013) on this topic. That meta-analysis found a significant increase risk in both breast and cervical cancer. They point out that given the high incidence of breast cancer, this means a substantial increase in the number of cases.

Contraceptives have been proven to increase the risk of blood clots, which can be fatal. They also have increased risk of causing heart disease, especially in smokers. These medications should not be prescribed by anyone except a medical doctor who has access to accurate medical records and the necessary medical tests.

Third, as Catholic medical physicians, we are opposed to contraceptives which have been proven to have an abortifacient effect. One of the proven mechanisms by which these drugs work is by impairing implantation of the developing embryo in the uterus. Essentially, they prevent the living embryo from implanting in the uterus and getting the necessary nutrients to grow and develop. During last session's public hearings, it was argued that oral contraceptives are not abortifacients, and that if they were, we would see an increase in ectopic pregnancies. This, anatomically, does not make sense. An egg is released from the ovary and travels down the fallopian tubes and into the uterus. If it is fertilized, it attempts to implant in the lining of the uterus. This is where the action of contraceptives act as an abortifacient. They have been shown to prevent implantation in the uterus. The vast majority of ectopic pregnancies, however, occur before this when the developing embryo implants in the fallopian tube. In other words, the embryo is already past the location of ectopic pregnancy when the oral contraceptives act to prevent implantation in the uterus. So, of course we do not see a rise in ectopic pregnancies. Furthermore, newer hormonal contraceptives have a lower dose of estrogen, resulting in more women actually ovulating and more fertilized embryos ending in "silent abortions" when the

embryo cannot implant due to the progesterone component of contraceptives altering the uterine lining.

Finally, the proposed legislation is reportedly to improve access to "healthcare" and birth control, with the anticipated effect of reducing unintended pregnancies. However, studies have shown this is not the case. A study from the Guttmacher Institute published March, 2017 found that almost half of unintended pregnancies occurred while the woman was using birth control. The same study also reported about half of pregnancies terminated by abortion had occurred while using contraceptives.

A second study done in Canada looked at the cost of unintended pregnancies and the role of imperfect adherence. They found that 68% of all unplanned pregnancies occurred while the woman had access to contraceptives, but had imperfect use. In other words, you can provide the contraceptives, but that does not solve the problem of unintended pregnancies.

In summary, the proposed bill allowing pharmacist prescription of contraceptives diminishes the value of the patient-physician relationship, ignores the significant medical risks of contraceptives and their abortifacient effect, and does not solve the problem of unintended pregnancies. As such, the WCMG opposes AB 36 and encourages you to do likewise.

Thank you for hearing my testimony, and I would be pleased to answer any questions from committee members.

References:

Oral contraceptive use and risk of breast, cervical, colorectal, and endometrial cancers: a systematic review. Gierisch JM, et al. Cancer Epidemiol Biomarkers Prev. 2013 Nov;22(11): 1931-43.

Contraceptive Failure in the United States: Estimates from the 2006-2010 National Survey of Family Growth. Sundaram A, et al. Perspectives on Sexual and Reproductive Health. 2017 Mar;49(1): 7-16.

The Cost of Unintended Pregnancies in Canada: Estimating Direct Cost, Role of Imperfect Adherence, and the Potential Impact of Increased Use of Long-Acting Reversible Contraceptives. Block et al. J. Oebstet Gynaecol Can. 2015 Dec;37(12):1086-97.

WISCONSIN CATHOLIC CONFERENCE

TO: Members, Assembly Committee on Health

FROM: Kim Vercauteren, Executive Director

DATE: October 7, 2021

RE: AB 36, Pharmacists Prescribing Contraceptives

The Wisconsin Catholic Conference (WCC), the public policy voice of the Catholic bishops of Wisconsin, urges you to oppose Assembly Bill 36, which allows pharmacists to prescribe certain hormonal contraceptives. This bill not only impacts women's health in Wisconsin, but also alters established medical standards and impacts the individual conscience rights of pharmacists.

The Catholic Church opposes the use of artificial contraception. However, the Church's objection to artificial contraception is not about trying to penalize or control individuals. It is about prizing the most creative power that we human beings possess. It is about protecting the human dignity of parents and their unborn children. It is about reminding society that women should not have to radically delay childbirth, artificially suppress their fertility, or ingest strong chemicals in order to get an education and participate in the workforce at every level.

The Church teaches that the use of artificial contraception restricts the total self-giving of spouses and introduces a "false note" in a marriage, sometimes causing one or both spouses to treat each other more like objects rather than people. In some cases, the failure of contraception may tempt couples to seek an abortion when an unwanted life is conceived. In other cases, hormonal contraception interferes with implantation, thus ending a new human life. Finally, scientists now recognize that the growing presence of hormonal contraceptives in our waterways is having an adverse effect on the environment and on aquatic species. For all these reasons, the Church encourages all to "go organic" and utilize Natural Family Planning rather than artificial hormonal contraception.

In addition to these concerns, pharmacist prescription of contraceptives could have adverse health impacts on both a woman and her unborn child. This is because under AB 36, there would be no requirements that a pharmacist test for pregnancy, order diagnostic exams that would provide a comprehensive assessment of a woman's current health status, or even have access to a woman's complete medical history and records, all of which normally inform the medical decision-making process. For example, hormonal contraception may be contraindicated if a woman has certain health conditions, such as hypertension, diabetes, certain types of migraines, or multiple risk factors for heart disease. A doctor would have access to the woman's full medical history, as well as diagnostic tests, but a pharmacist would not.

(over)

106 E. Doty Street • Suite 305 • Madison, WI 53703
Tel 608/257-0004 • Fax 608/257-0376 • Website http://www.wisconsincatholic.org

Furthermore, while AB 36 charges certain state entities with designing the standards and rules for implementing pharmacist prescribing, these requirements are limited by the bounds of state law regarding who may engage in the practice of medicine.

Lastly, in an era when public health advocates and policy makers are trying to improve comprehensive and high-quality primary care through regular patient-provider interactions, it is difficult to understand the need for a law that discourages individuals from annually meeting with their primary provider.

In permitting pharmacists to prescribe contraceptives, the bill also significantly alters the current legal requirements for dispensing prescriptions. Currently under Wisconsin Statutes s. 450.095, the duty to dispense lies with a pharmacy, not the individual pharmacist. A pharmacy may forgo filling a prescription if it is incompatible with another drug or device prescribed for the patient, is prohibited by state or federal law, or is fraudulent, among other reasons.

Under AB 36, once a pharmacist opts to prescribe contraceptives, the bill directs the pharmacist to then dispense the contraception. However, what if a pharmacist were to learn, after writing the prescription, of new information that would trigger a need to forgo dispensation, such as the customer committed fraud and lied about their age? It is uncertain, given the AB 36's mandate to dispense, whether the pharmacist must continue to dispense in these circumstances.

Also, the current pharmacy duty to dispense preserves an individual pharmacist's right of conscience. This aligns with Article I, Section 18 of our Wisconsin Constitution, which explicitly affirms, "nor shall any control of, or interference with, the rights of conscience be permitted." Should AB 36 become law, commercial pharmacy chains will likely make corporate policies instituting mandatory prescribing for their pharmacists, negating the permissive choice for pharmacists highlighted by AB 36's supporters. Facilitating a commercial market where pharmacists will be expected to prescribe contraception will drive pharmacists of conscience to other states, including those that surround Wisconsin, where no such pressure to prescribe contraceptives exists.

As a Church, we recognize an inherent and inalienable dignity in every human being. Our health care system should preserve this dignity by ensuring that best practice standards are observed when prescribing synthetic hormonal medications to women. Legislation that fails to promote and protect our humanity and coerces the conscience of medical professionals should not be supported. We urge you to oppose AB 36.

Contact: Connie Schulze
Director, Government Affairs
Madison, WI 53705
608/516-2552 mobile
cschulze@uwhealth.org

Assembly Committee on Health
Testimony in Support of Assembly Bill 36
Submitted by Laurel Rice, MD
Chair, Department of Obstetrics/Gynecology
October 7, 2021

Dear Chairman Sanfelippo and members of the committee:

Thank you for this opportunity to share my support for Assembly Bill 36 (AB36) as introduced by Rep. Joel Kitchens, Sen. Mary Felzkowski and Sen. Kathy Bernier. I currently serve as the Chair of the Department of Obstetrics and Gynecology and as a professor in the Division of Gynecologic Oncology at the University of Wisconsin School of Medicine and Public Health. However, I began my career in health care as a licensed pharmacist, having worked my way through medical school from behind the pharmacy counter. The understanding of women's health care that I have gleaned from both roles makes me uniquely qualified to weigh-in on this legislation.

In practice both as an OB/GYN and as a pharmacist, I have seen first-hand the need for easily accessible and reliable contraceptives. Women, children and families benefit from contraceptives that help to prevent unplanned pregnancies. Efforts to expand access to birth control options like the "patch" and the "pill" should be supported because they are safe and effective. While it's true they are only available by prescription, decades of research have demonstrated there is little chance of abuse with these medications and the side effects are minimal. So much so that many experts in health care believe the FDA should make them readily available over-the-counter, as is the case in many other developed nations.

With access in-mind, I see AB36 as a step in the right direction. Wisconsin faces a growing physician shortage and the consequence of that shortage is limited access to care in many areas of the state. In fact, data released by the American Medical Association in 2019 indicates 29 of Wisconsin's 72 counties have only one OB/GYN or none at all. By expanding access to safe and reliable contraceptives like the patch and the pill through licensed pharmacists, we are offering a work around to that shortage. Of course, as a physician I feel strongly that all health care providers should practice to the top of their license but not outside the scope of their expertise. I am confident Wisconsin's licensed pharmacists are qualified to undertake the task of prescribing and dispensing hormonal contraceptives which is already the practice in 12 states.

As you explore the implications of the proposed public policy, I'll leave you with one final thought. That is the financial burden of unplanned pregnancy. The Guttmacher Institute has researched associated costs and determined in Wisconsin, almost 63 percent of unplanned births are publicly-funded, with federal and state governments spending $313.5 million each year on this care. Of that total, $221.4 million is paid for by federal tax dollars and $92.1 million by state tax dollars. The total public cost for unintended pregnancies in Wisconsin is $286 per woman, which is considerably higher than the national average of $201 per woman. Nevertheless, we can turn the tide. A similar law passed in Oregon and it was found to have prevented more than 50 unintended pregnancies and saved an estimated $1.6 million in associated taxpayer costs in the first two years the law went into effect, according to a study from Oregon State University.

For the reasons I have outlined above, I hope you see fit to join me in supporting AB36. Thank you for your consideration.