JOEL KITCHENS

STATE REPRESENTATIVE • 1ST ASSEMBLY DISTRICT

Testimony for the Senate Committee on Health
Assembly Bill 176/Senate Bill 211
Room 411 South
July 12, 2023

Thank you Chairperson Cabral-Guevara and committee members for holding a public hearing and allowing me to testify on Assembly Bill 176 and Senate Bill 211, 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.

Our bill 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.

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.

The questionnaire must state and the patient must acknowledge that contraceptives are not a protection against sexually transmitted diseases and strongly recommend that patients meet with a medical professional annually to discuss contraceptive treatments and other routine preventive care.

If there are any red flags, the pharmacist will not prescribe and dispense birth control and will 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 practitioner. 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.

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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 far less rigorous than that prescribed in this bill.

It's important to note that this bill only applies to women who are at least 18 years of age.

One of the reasons we introduced this bill is because of the high costs associated with unplanned pregnancies.

According to the latest available statistics, nearly half of the 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 62 percent of unplanned births are publicly 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 of 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 her future earning potential and her family's financial well-being. Community colleges are typically the place first-generation college students begin their postsecondary 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.

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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 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 changed. Decades of research have 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 in 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

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cancer. While there is a slightly 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. 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

There are a couple of groups who are opposed to any birth control on moral grounds. I respect moral convictions. If you would stick with moral arguments and argue for a ban on birth control, I'd be fine.

The reality is 90% of women use oral contraceptives during their life. A very small minority is trying to impose their morals on the rest of us at a very high price. So instead, they put out misinformation attacking safety & efficacy.

This bill has been passed twice. We all know what you will hear today. Groups will throw everything at the wall, hoping something will stick. My favorite, last time, was that men would grow breasts from birth control. Lobbyists who majored in political science & the humanities are telling you they know better than the medical community. The only medical group opposed – coincidentally is the Catholic Physicians Guild also will twist science to justify the moral position.

I will address a couple of the criticisms you may hear from opponents of this bill. While these critics may not agree with many of the things I'm about to say, if you have 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.
- They will probably cite a study saying that claims 2/3rds of unplanned pregnancies happen with women using birth control, inferring that those are women on hormonal contraceptives.
    - That study counted women using any type of pregnancy prevention, including the rhythm method and withdrawal.
- There is always room for some human error, but when used consistently and correctly, oral contraceptives are 99.9% effective.
- In reality, 95% of unintended pregnancies are attributed to one-third of women who do not use contraceptives or who use them inconsistently.

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The primary cause of irregular use is lack of access. I think it is ironic that 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 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 has been disproven-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 the implantation of a viable embryo. ACOG says that this label was written in 1999 and does not reflect current research or the opinion of the medical community.

I am also hearing from critics of this legislation that birth control 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 abortions. "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 by 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, this bill will have a far greater impact on reducing the number of abortions in Wisconsin than most 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 28 states that have passed or are in the process of allowing women to get their birth control prescriptions from a pharmacy, as well as Washington, D.C. This is not a Republican or

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Democratic issue. Most of the states to recently enact this legislation have been red states. In previous years North Carolina, Arkansas, Arizona, Illinois, and Nevada have passed this legislation. Arizona is the most recent state to sign similar legislation into law.

Oregon was the first state to pass a 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 after the law went into effect. Knowing that 40 percent of unplanned pregnancies end in abortion means 20 fewer abortions occur.

As you can see, we are proposing AB 176 and SB 211 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 on 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 these bills. I am also extremely appreciative 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 you have.

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MARY FELZKOWSKI
STATE SENATOR • 12TH SENATE DISTRICT

Testimony on SB 211 & AB 176

Senate Committee on Health
Senator Mary Felzkowski
12th Senate District
July 12, 2023

Good afternoon Chairwoman Cabral-Guevara and fellow Committee Members,

Thank you for taking the time to hear testimony on Senate Bill 211/Assembly Bill 176, which would allow pharmacists to prescribe oral birth control in Wisconsin.

As you just heard from my co-author, Representative Kitchens, 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 more than 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 27 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.

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Testimony before the Senate Committee on Health

Assembly Bill 176/Senate Bill 211

July 12, 2023

Thank you Chair Cabral-Guevara, and members of the Senate Committee on Health for holding this hearing on Assembly Bill (AB) 176/Senate Bill (SB) 211, 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. The Legislative Reference Bureau has provided an excellent synopsis in the analysis section of this Bill.

As a retired nurse and nurse educator I find value in recommending, to the women who receive these contraceptives directly from a pharmacist, regular visits with a physician or other medical professional to discuss the prescribed contraceptive treatment. Also, these women need to know that hormonal birth control does not prevent against the spread of sexually transmitted infections (STIs). This risk of contracting an SIT greatly increases with the number of sexual partners one has. Which is why, last session, I advocated for this provision to be added via an amendment. I am pleased to see this language is included in AB 176/SB 211.

Additionally, as a pro-life legislator, I support AB 176/SB 211 because it provides women with access to contraception and with responsible use, it will prevent some crisis pregnancies from occurring. I believe that if we do not want babies aborted, we should provide access to resources to prevent crisis pregnancies.

Unfortunately, due to a scheduling conflict, I was unable to attend this hearing. Thank you for reviewing my written testimony and for your support of this Bill. If you have any questions regarding my testimony or support of AB 176/SB 211, please reach out to my office and I will respond at my earliest convenience.

State of Wisconsin
Department of Health Services

Tony Evers, Governor
Kirsten L. Johnson, Secretary

TO: Members of the Senate Committee on Health

FROM: HJ Waukau, Legislative Director

DATE: July 12, 2023

RE: SB 211/AB 176 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

The Department of Health Services (DHS) would like to submit written testimony for information only on Senate Bill 211 (SB 211) and Assembly Bill 176 (AB 176), regarding 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.

Per the requirements of 2021 Wisconsin Act 98, DHS must reimburse pharmacists for services delivered under their scope of practice and per a collaborative practice agreement with a physician. If the scope of practice laws for pharmacists change, so would the services that DHS would reimburse for pharmacists. As drafted, SB 211/AB 176 would expand a pharmacist's scope of practice to include prescribing contraceptives. Consistent with 2021 Act 98, were SB 211/AB 176 to become law DHS would then cover contraceptives prescribed by a pharmacist as specified under law and regulations promulgated by the Pharmacy Examining Board. In doing so, SB 211/AB 176 could help increase access to contraceptives across the state. Additionally, as of January 2022, 23 other states have allowed pharmacists to prescribe contraceptives in some form.

Further, because of 2021 Act 98 DHS holds that Section 1 of SB 211/AB 176 is duplicative of Act 98 and could be removed. The provisions of SB 211/AB 176 increasing the scope of practice for pharmacists would automatically be addressed by DHS per Wis. Stat § 49.46(2)(bh), which states, "the department shall provide reimbursement for services that are reimbursable under this section and that are provided by a licensed pharmacist within the scope of his or her license or are services performed under s. 450.033." DHS recommends that SB 211/AB 176 be amended to remove Section 1 to avoid any confusion or duplication of requirements in state statute.

DHS thanks the Committee for the opportunity to provide written testimony for information only on SB 211/AB 176 and we offer ourselves as a resource for Committee members for any follow up or additional information that may be needed.

To: Members, Senate Committee on Health

From: Marina Maes, PharmD, BCPS, BCACP
Assistant Professor, Pharmacy Practice & Translational Research
Primary Care Pharmacist

Date: July 12, 2023

Subject: Testimony in Support of Assembly Bill 176 / Senate Bill 211

Members of the Committee, thank you for your time today and for allowing me to provide testimony in favor of Assembly Bill 176 and Senate Bill 211. My name is Marina Maes, and I am a faculty member at a School of Pharmacy and a primary care pharmacist. I teach women's health pharmacotherapy topics to pharmacy students. I educate students on all things related to the safe use of contraceptive medications, including their mechanism of action, drug-drug interactions, adverse effects, and contraindications. In my primary care clinical practice, I also educate family medicine medical residents about contraception, including how to select an appropriate contraceptive medication for an individual patient.

According to the CDC, nearly half of all pregnancies are unintended.[1] An unintended pregnancy is a pregnancy that is either unwanted (ie, the pregnancy occurred when no children or no more children were desired) or mistimed (ie, the pregnancy occurred earlier than desired). Unintended pregnancies are associated with poor outcomes for both mother and infant, including low birth weight, shorter duration of breastfeeding, increased postpartum depression and parental stress, physical and psychological abuse, and maternal mortality. Furthermore, unintended pregnancy disproportionately impacts marginalized populations, including those with low income, those who have not completed high school, and Black individuals. Finally, unintended pregnancies often end in abortion (21% in Wisconsin) and are costly to individuals and society as a whole. In 2010, $21 billion was spent by state and federal governments nationwide. In Wisconsin, 62% of unplanned births were publicly 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]

Unintended pregnancies can be prevented with access to reproductive healthcare services, which includes access to contraception. Pharmacists are uniquely positioned to provide these services within community pharmacies. Not only are community pharmacists the most accessible healthcare providers, with 99.7% of the Wisconsin population living within 30 minutes of a pharmacy and 89.3% living within 10 minutes of a pharmacy, but they also have the skills and training necessary to offer these services to patients.[3]

This bill proposes that pharmacists will be able to prescribe and dispense certain self-administered hormonal contraception, including the pill and the patch, to individuals 18 years and older. Pharmacist-prescribed hormonal contraception is evidence-based and has been studied to show feasibility and safety. Per the American College of Obstetricians and Gynecologists (ACOG) and the CDC's U.S. Selected Practice Recommendations for Contraceptive Use, a hormonal contraceptive pill and patch can be prescribed without a physical exam or other tests.[4,5] The only physical assessment needed prior to prescribing a hormonal contraceptive is a blood pressure assessment which pharmacists are trained to perform and evaluate. This bill also requires pharmacists to administer a self-assessment

questionnaire completed by the patient, which will allow the pharmacist to evaluate whether a patient is a candidate for hormonal contraception based on their medical history.

You may hear from others that it would be difficult for pharmacists to evaluate whether hormonal contraception is truly safe for a patient without access to the patient's medical records because they may not always know their medical conditions. However, a study has actually been conducted to evaluate this where women completed a questionnaire on their own, and then their provider completed a medical evaluation of them.[6] The estimated proportion of overall agreement between the patient's self-identified risk factors and the provider's evaluation of risk factors was 96%. When there was a disagreement, it was actually because women were more likely to identify contraindications than their providers. This gives reassurance that the self-administered questionnaire is sufficient to identify whether an individual has risk factors that would preclude them from using a hormonal contraceptive. Additionally, pharmacists can see exactly which medications the patient is filling at their pharmacy, allowing them to check for drug-drug interactions and ask clarifying questions about their medical history if needed.

As a pharmacist who works in a rural primary care clinic, I have seen firsthand how challenging it can be for patients to get in for an appointment with their primary care provider. The providers' schedules are booked 2 to 3 months out, which limits patient access to timely and convenient care from a trusted healthcare professional. Additionally, our patients have their own barriers, including transportation to the clinic and taking time off of work. In my role, I am able to support and care for patients to manage their chronic conditions and medication-related needs in between visits with their primary care physicians in a way that is timely and convenient. For example, I call patients to obtain their blood glucose readings and make dose adjustments to their diabetes medications; I help navigate insurance issues to ensure patients can actually obtain their medications; I triage calls from patients related to medication side effects and make recommendations for how to manage. Additionally, the attending physicians and medical residents utilize me and my medication expertise to assist them in clinical decision-making to optimize patient care. They value the knowledge and skills that I bring as a pharmacist to complement the work they do. In my clinic, I play a crucial role in offloading work from primary care physicians and contributing to the efficient and effective delivery of healthcare services. This is true for pharmacists across a multitude of practice settings. There are currently several mechanisms in which pharmacists are already involved in prescribing certain medications in our state and across the nation. So, the concept of pharmacists prescribing medications is not new and is definitely within our scope of practice. As an educator of future pharmacists, I can see the eagerness amongst our students to fill these roles and provide these advanced services.

Pharmacists practicing in community settings can further increase access to important healthcare services, including prescribing contraception. This legislation would help those individuals who need effective contraception and cannot take time off of work for an office visit between the hours of 8 am-5 pm but can go to the pharmacy after work at 6 pm. This legislation would help those individuals who need effective contraception but cannot get in to see their primary care physician for another 3 months. This legislation would help those individuals who had 5 concerns to talk about with their primary care physician in a 20-minute visit and were unable to get to the topic of contraception. The primary care physician shortage is not going away. The 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.[7] The purpose of this legislation is truly to increase access for patients and to utilize the expertise of an interprofessional workforce. This is not intended to replace the physician-patient relationship but rather to

strengthen and expand the team of professionals that can support and care for patients in our state.

I ask that you support Assembly Bill 176 and Senate Bill 211, as pharmacist-prescribed contraception is key to increasing patient access resulting in potentially fewer unintentional pregnancies and elective abortions, improved patient outcomes, and reduced costs for federal and state governments. I strongly believe pharmacists are highly qualified to prescribe hormonal contraceptives like the pill and patch safely and effectively.

Thank you again for the opportunity to provide testimony in favor of Assembly Bill 176 and Senate Bill 211. I welcome any questions that you may have.

References:

1. Unintended Pregnancy. Centers for Disease Control and Prevention. Accessed June 5, 2023. https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/index.htm
2. State Facts About Unintended Pregnancy: Wisconsin. Guttmacher Institute. 2014. https://www.guttmacher.org/sites/default/files/factsheet/wi_5.pdf. Accessed October 4, 2021.
3. Look K, Dekeyser C, Conjurske S, et al. Illustrating access to community pharmacies in Wisconsin. *J Am Pharm Assoc.* 2021;61(4):492-499. doi:10.1016/j.japh.2021.02.004
4. 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.
5. 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.
6. Shotorbani S, Miller L, Blough D, Gardner J. Agreement between women's and providers' assessment of hormonal contraceptive risk factors. *Contraception.* 2006;73(5):501-506.
7. 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 June 5, 2023.

WISCONSIN CATHOLIC CONFERENCE

TO: Senator Rachael Cabral-Guevara, Chair
Members, Senate Committee on Health

FROM: Barbara Sella, Executive Director

DATE: July 12, 2023

RE: Opposition to SB-211, Permitting Pharmacists to Prescribe Certain Contraceptives

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The Wisconsin Catholic Conference (WCC), the public policy voice of the Catholic bishops of Wisconsin, urges you to oppose Senate Bill 211, which allows pharmacists to prescribe certain hormonal contraceptives. This bill not only negatively impacts women's health in Wisconsin, but also alters established medical standards and harms the individual conscience rights of pharmacists.

Pharmacists prescribing contraceptives does not best serve the health of women in our state. Under SB-211, there are 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. A doctor would have access to the woman's full medical history, as well as diagnostic tests, but a pharmacist would only be able to rely on self-assessment.

Hormonal contraceptives are strong drugs that have been shown to increase the risk of serious diseases.[1] Oral contraceptives have been associated with increased risk of depression;[2] venous thromboembolism (VTE);[3] thrombotic stroke and myocardial infarction;[4] HIV-1 acquisition and transmission;[5] breast and cervical cancer;[6] hypertension;[7] and bone fractures, Crohn's disease, ulcerative colitis, systemic lupus erythematosus, and other autoimmune diseases.[8] Due to these risks, hormonal contraceptives are not meant to be taken without thorough evaluation and ongoing consultation with a doctor. Today when public health advocates and policy makers are trying to increase regular patient interactions with their primary care providers, it is difficult to understand a law that disincentivizes individuals from seeking such care.

In permitting pharmacists to prescribe contraceptives, the bill 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. This preserves an individual pharmacist's right of conscience and 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 SB-211 become law, commercial pharmacy chains will likely institute corporate policies requiring mandatory prescribing for their pharmacists, undermining the argument that pharmacists will not be forced to prescribe.

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While the Catholic Church opposes the use of artificial contraception with contraceptive intent, it is not opposed to the use of contraceptives for treatment of a medical disorder, such as heavy menstrual bleeding. However, fertility is not a disorder or disease. In addition, sometimes the failure of contraception can prompt couples to seek an abortion when an unexpected life is conceived.

Furthermore, now that there exist effective fertility-awareness-based methods, such as the Marquette Method developed here in Wisconsin, that give women the tools they need to understand their own reproductive health, the State of Wisconsin should not be pushing for the expansion of powerful artificial drugs.

Whether or not one agrees with the Church's stance on contraception, there are serious risks that should give everyone pause. Legislation that fails to promote and protect women's health and coerces the conscience of individual pharmacists should not be supported. We respectfully urge you to oppose SB-211.

References

[1] Rebecca Peck & Charles W. Norris, *Significant Risks of Oral Contraceptives (OCPs): Why This Drug Class Should Not Be Included in a Preventive Care Mandate*, 79 Linacre Quarterly 41, 42 (Feb. 2012), https://doi.org/10.1179%2F002436312803571447.

[2] Charlotte Wessel Skovlund, et al., *Association of Hormonal Contraception with Depression*, JAMA Psychiatry (Sept. 2016), https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2552796 ("Use of hormonal contraception, especially among adolescents, was associated with subsequent use of antidepressants and a first diagnosis of depression, suggesting depression as a potential adverse effect of hormonal contraceptive use.") *See also* Eveline Mu and Jayashri Kulkarni, *Hormonal contraception and mood disorders*, Australian Prescriber, 45(3): 75–79 (Jun. 2022). https://doi.org/10.18773/austprescr.2022.025 ("There is evidence to suggest that both oestrogen and progesterone influence brain function, which may be responsible for the negative mood changes and depression commonly reported in women taking oral contraceptive pills. One of the most common reasons given for the discontinuation of oral contraceptive pills is changes in mood or an increase in depressive symptoms.")

[3] Peck & Norris, *supra*, at 43 ("Oral contraceptives are associated with a three to five times higher risk of VTE"); *see also* Yana Vinogradova, et al., *Use of Combined Oral Contraceptives and Risk of Venous Thromboembolism: Nested Case-Control Studies Using the QResearch and CPRD Databases*, BMJ (Mar. 19, 2015), https://www.bmj.com/content/350/bmj.h2135 ("Current exposure to any combined oral contraceptive was associated with an increased risk of venous thromboembolism … compared with no exposure in the previous year."); *see also* Robert A. Hatcher et al., *Contraceptive Technology,* 18th rev. ed. (New York: Ardent Media, 2004), at 405-07. A 2018 systematic review of evidenced-based articles from the 1960s to 2018 concluded that "136-260 women die from VTE a year in the United States from hormonal contraception." William V. Williams, et al., *Hormonally Active Contraceptives Part I: Risks Acknowledged and Unacknowledged*, THE LINACRE QUARTERLY 126-48 (May 2021), https://pubmed.ncbi.nlm.nih.gov/33897046, citing L. Keenan, et al., *Systematic Review of Hormonal Contraception and Risk of Venous Thrombosis*, The Linacre Quarterly, 470-77 (Nov. 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6322116.

[4] Ojvind Lidegaard, et al., *Thrombotic Stroke and Myocardial Infarction with Hormonal Contraception*, New England Journal of Medicine 366:2257-2266 (Jun. 2012), https://www.nejm.org/doi/full/10.1056/nejmoa1111840 (finding that risks of thrombotic stroke and myocardial infarction were "increased by a factor of 0.9 to 1.7 with oral contraceptives that included ethinyl estradiol at a dose of 20 mg and by a factor of 1.3 to 2.3 with those that included ethinyl estradiol at a dose of 30 to 40 mg"); Peck & Norris, *supra*, at 45 (reporting a 200 percent increase in the risk of myocardial infarction among users of low-dose oral contraceptives); *see also* Hatcher, *supra*, at 404-05, 445.

[5] Renee Heffron, et al., *Use of Hormonal Contraceptives and Risk of HIV-1 Transmission: A Prospective Cohort Study*, The Lancet 12(1):19-26 (Jan. 2012), https://pubmed.ncbi.nlm.nih.gov/21975269 ("Use of hormonal contraceptives was associated with a two-times increase in the risk of HIV-1 acquisition by women and HIV-1 transmission from women to men."); *see also Hormonal Contraception Doubles HIV Risk, Study Suggests,* Science Daily (Oct. 2011), https://www.sciencedaily.com/releases/2011/10/111003195253.htm.

[6] NIH Fact Sheet, *Oral Contraceptives and Cancer Risk* (Feb. 2018), https://www.cancer.gov/about-cancer/causes-prevention/risk/hormones/oral-contraceptives-fact-sheet. A 2023 study published in PLOS Medicine by researchers at Oxford Population Health's Cancer Epidemiology Unit found that use of combined oral or progestogen-only hormonal contraceptives is associated with a 20-30% higher risk of breast cancer: Danielle Fitzpatrick, et al., *Combined and progestagen-only hormonal contraceptives and breast cancer risk: A UK nested case–control study and meta-analysis*, PLOS Med 20(3) (Mar. 2023), https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1004188.

[7] Hatcher, *supra n. 3*, at 407, 445.

[8] Williams et al., *Hormonally Active Contraceptives*, *supra n. 3*.

WISCONSIN CATHOLIC MEDICAL GUILDS

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

July 12, 2023

To: Members, Senate Committee on Health

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

RE: AB 176/SB 211 – permitting pharmacists to prescribe certain contraceptives

Good afternoon, Chairwoman Cabral-Guevara 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) 176 and Senate Bill (SB) 211 and strongly urges you to not pass these bills out of committee.

As you know, AB 176/SB 211 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. The survey may "strongly recommend" a patient meet annually with a physician, but there is no measure in place to make sure this occurs. The patient may have to acknowledge that sexually transmitted illnesses are not prevented with contraceptives, but a pharmacist is not giving counseling on the risks of STI's; not giving recommendations for testing for STI's such as gonorrhea, chlamydia, syphilis, or HIV; and not providing follow-up for monitoring of potential side effects or changes in the patient's health status.

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

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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 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 anywhere near 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 increased risk in both breast and cervical cancer from hormonal contraceptive use. They point out that given the high incidence of breast cancer, this means a substantial increase in the number of cases. In fact, the National Cancer Institute verifies the increased risk of breast and cervical cancer in their data.

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. Without the necessary medical evaluation, this bill will cause a delay in diagnosis, and missed diagnosis of potentially life-threatening diseases.** Essentially, by allowing a pharmacist to prescribe and dispense these medications, this bill will decrease the quality of healthcare a woman receives and increase her risk of significant medical diseases. Women deserve better healthcare than this.

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. It has been argued that oral contraceptives are not abortifacients, and that if

they were, we would see an increase in ectopic pregnancies. This argument, anatomically, does not make sense. An egg is released from the ovary and travels down the fallopian tubes and into the uterus. If it was fertilized in the fallopian tube, it attempts to implant in the lining of the uterus. It is in the uterus where the contraceptives act as an abortifacient by preventing implantation. The vast majority of ectopic pregnancies, however, occur when the developing embryo implants in the fallopian tube. In other words, the embryo is already past the location of an 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 176/SB 211 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.

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

Pages 1,2 .....Color coded in the left column to match the corresponding question of the Oregon Hormonal Contraception Self-Screening Tool Questionnaire.
Pages 3,4 ..... Arranged alphabetically by disease state

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

Updated November 2016. This summary sheet only contains a subset of the recommendations from the US MEC. For complete guidance, see: http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm

Corresponding to the order of the Colorado Hormonal Contraception Self Screening Tool Questionnaire:

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Other Contraception Options Indicated for Patient
		Initiating	Continuing	Initiating	Continuing	
Age		Menarche to <40=1		Menarche to <18=1		Yes
		≥40=2		18-45=1		Yes
				>45=1		Yes
Smoking	a) Age < 35	2		1		Yes
	b) Age ≥ 35, < 15 cigarettes/day	3		1		Yes
	c) Age ≥ 35, ≥15 cigarettes/day	4		1		Yes
Pregnancy	(Not Eligible for contraception)	NA*		NA*		NA*
Postpartum (see also Breastfeeding)	a) < 21 days	4		1		Yes
	b) 21 days to 42 days:					
	(i) with other risk factors for VTE	3*		1		Yes
	(ii) without other risk factors for VTE	2		1		Yes
	c) > 42 days	1		1		Yes
Breastfeeding (see also Postpartum)	a) < 1 month postpartum	3*		2*		Yes
	b) 1 month or more postpartum	2*		1*		Yes
Diabetes mellitus (DM)	a) History of gestational DM only	1		1		Yes
	b) Non-vascular disease					
	b) Other abnormalities:					
	(i) non-insulin dependent	2		2		Yes
	(ii) insulin dependent‡	2		2		Yes
	c) Nephropathy/ retinopathy/ neuropathy‡	3/4*		2		Yes
	d) Other vascular disease or diabetes of >20 years' duration‡	3/4*		2		Yes
Headaches	a) Non-migrainous	1*	2*	1*	1*	Yes
	b) Migraine:					
	i) without aura, age <35	2*	3*	1*	2*	Yes
	ii) without aura, age ≥35	3*	4*	1*	2*	Yes
	iii) with aura, any age	4*	4*	2*	3*	Yes
Hypertension	a) Adequately controlled hypertension	3*		1*		Yes
	b) Elevated blood pressure levels (properly taken measurements):					
	(i) systolic 140-159 or diastolic 90-99	3		1		Yes
	(ii) systolic ≥160 or diastolic ≥100‡	4		2		Yes
	c) Vascular disease	4		2		Yes
History of high blood pressure during pregnancy		2		1		Yes
Hyperlipidemias		2/3*		2*		Yes
Peripartum cardiomyopathy‡	a) Normal or mildly impaired cardiac function:					
	(i) < 6 months	4		1		Yes
	(ii) ≥ 6 months	3		1		Yes

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Other Contraception Options Indicated for Patient
		Initiating	Continuing	Initiating	Continuing	
	b) Moderately or severely impaired cardiac function	4		2		Yes
Multiple risk factors for arterial cardiovascular disease	(such as older age, smoking, diabetes and hypertension)	3/4*		2*		Yes
Ischemic heart disease‡	Current and history of	4		2	3	Yes
Valvular heart disease	a) Uncomplicated	2		1		Yes
	b) Complicated‡	4		1		Yes
Stroke‡	History of cerebrovascular accident	4		2	3	Yes
Thrombogenic mutations‡		4*		2*		Yes
Deep venous thrombosis (DVT) /Pulmonary embolism (PE)	a) History of DVT/PE, not on anticoagulant therapy					
	i) higher risk for recurrent DVT/PE	4		2		Yes
	ii) lower risk for recurrent DVT/PE	3		2		Yes
	b) Acute DVT/PE	4		2		Yes
	c) DVT/PE and established on anticoagulant therapy for at least 3 months					
	i) higher risk for recurrent DVT/PE	4*		2		Yes
	ii) lower risk for recurrent DVT/PE	3*		2		Yes
	d) Family history (first-degree relatives)	2		1		Yes
	e) Major surgery					
	(i) with prolonged immobilization	4		2		Yes
	(ii) without prolonged immobilization	2		1		Yes
	f) Minor surgery without immobilization	1		1		Yes
History of bariatric surgery‡	a) Restrictive procedures	1		1		Yes
	b) Malabsorptive procedures	COCs: 3		3		Yes
Breast disease/ Breast Cancer	a) Undiagnosed mass	2*		2*		Yes
	b) Benign breast disease	1		1		Yes
	c) Family history of cancer	1		1		Yes
	d) Breast cancer:‡					
	i) current	4		4		Yes
	ii) past and no evidence of current disease for 5 years	3		3		Yes

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Other Contraception Options Indicated for Patient
		Initiating	Continuing	Initiating	Continuing	
Viral hepatitis	a) Acute or flare	3/4*	2	1		Yes
	b) Carrier/Chronic	1	1	1		Yes
Cirrhosis	a) Mild (compensated)	1		1		Yes
	b) Severe‡ (decompensated)	4		3		Yes
Liver tumors	a) Benign:					
	i) Focal nodular hyperplasia	2		2		Yes
	ii) Hepatocellular adenoma‡	4		3		Yes
	b) Malignant‡	4		3		Yes
Gallbladder disease	a) Symptomatic:					
	(i) treated by cholecystectomy	2		2		Yes
	(ii) medically treated	3		2		Yes
	(iii) current	3		2		Yes
	b) Asymptomatic	2		2		Yes
History of Cholestasis	a) Pregnancy-related	2		1		Yes
	b) Past COC-related	3		2		Yes
Systemic lupus erythematosus‡	a) Positive (or unknown) antiphospholipid antibodies	4		3		Yes
	b) Severe thrombocytopenia	2		2		Yes
	c) Immunosuppressive treatment	2		2		Yes
	d) None of the above	2		2		Yes
Rheumatoid arthritis	a) On immunosuppressive therapy	2		1		Yes
	b) Not on immunosuppressive therapy	2		1		Yes
Blood Conditions?						
Epilepsy‡	(see also Drug Interactions)	1*		1*		Yes
Tuberculosis‡ (see also Drug Interactions)	a) Non-pelvic	1*		1*		Yes
	b) Pelvic	1*		1*		Yes
HIV	High risk	1		1		Yes
	HIV infected (see also Drug Interactions)‡	1*		1*		Yes
	AIDS (see also Drug Interactions) ‡	1*		1*		Yes
	Clinically well on therapy	If on treatment, see Drug Interactions.				
Antiretroviral therapy	a) Nucleoside reverse transcriptase inhibitors	1*		1		Yes
	b) Non-nucleoside reverse transcriptase inhibitors	2*		2*		Yes
	c) Ritonavir-boosted protease inhibitors	3*		3*		Yes
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3*		3*		Yes
	b) Lamotrigine	3*		1		Yes
Antimicrobial therapy	a) Broad spectrum antibiotics	1		1		Yes
	b) Antifungals	1		1		Yes
	c) Antiparasitics	1		1		Yes
	d) Rifampicin or rifabutin therapy	3*		3*		Yes

Alphabetical Listing of USMEC Contraceptive Eligibility By Disease State

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Other Contraception Options Indicated for Patient
		Initiating	Continuing	Initiating	Continuing	
Breast disease/ Breast Cancer	a) Undiagnosed mass	2*		2*		Yes
	b) Benign breast disease	1		1		Yes
	c) Family history of cancer	1		1		Yes
	d) Breast cancer‡					
	i) current	4		4		Yes
	ii) past and no evidence of current disease for 5 years	3		3		Yes
Breastfeeding (see also Postpartum)	a) < 1 month postpartum	3*		2*		Yes
	b) 1 month or more postpartum	2*		1*		Yes
Cervical cancer	Awaiting treatment	2		1		Yes
Cervical ectropion		1		1		Yes
Cervical intraepithelial neoplasia		2		1		Yes
Cirrhosis	a) Mild (compensated)	1		1		Yes
	b) Severe‡ (decompensated)	4		3		Yes
Cystic Fibrosis		1*		1*		Yes
Deep venous thrombosis (DVT) /Pulmonary embolism (PE)	a) History of DVT/PE, not on anticoagulant therapy					
	i) higher risk for recurrent DVT/PE	4		2		Yes
	ii) lower risk for recurrent DVT/PE	3		2		Yes
	b) Acute DVT/PE	4		2		Yes
	c) DVT/PE and established on anticoagulant therapy for at least 3 months					
	i) higher risk for recurrent DVT/PE	4*		2		Yes
	ii) lower risk for recurrent DVT/PE	3*		2		Yes
	d) Family history (first-degree relatives)	2		1		Yes
	e) Major surgery					
	(i) with prolonged immobilization	4		2		Yes
	(ii) without prolonged immobilization	2		1		Yes
	f) Minor surgery without immobilization	1		1		Yes
Depressive disorders		1*		1*		Yes
Diabetes mellitus (DM)	a) History of gestational DM only	1		1		Yes
	b) Non-vascular disease					
Diabetes mellitus (cont.)	(i) non-insulin dependent	2		2		Yes
	(ii) insulin dependent‡	2		2		Yes
	c) Nephropathy/ retinopathy/ neuropathy‡	3/4*		2		Yes
	d) Other vascular disease or diabetes of >20 years' duration‡	3/4*		2		Yes
Endometrial cancer‡		1		1		Yes
Endometrial hyperplasia		1		1		Yes
Endometriosis		1		1		Yes
Epilepsy‡	(see also Drug Interactions)	1*		1*		Yes
Gallbladder disease	a) Symptomatic					
	(i) treated by cholecystectomy	2		2		Yes
	(ii) medically treated	3		2		Yes
	(iii) current	3		2		Yes
	b) Asymptomatic	2		2		Yes

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Other Contraception Options Indicated for Patient
		Initiating	Continuing	Initiating	Continuing	
Gestational trophoblastic disease	a) Decreasing or undetectable ß-hCG levels	1		1		Yes
	b) Persistently elevated ß-hCG levels or malignant disease‡	1		1		Yes
Headaches	a) Non-migrainous	1*	2*	1*	1*	Yes
	b) Migraine					
	i) without aura, age <35	2*	3*	1*	2*	Yes
	ii) without aura, age ≥35	3*	4*	1*	2*	Yes
	iii) with aura, any age	4*	4*	2*	3*	Yes
History of bariatric surgery‡	a) Restrictive procedures	1		1		Yes
	b) Malabsorptive procedures	COCs: 3 P/R: 1		3		Yes
History of cholestasis	a) Pregnancy-related	2		1		Yes
	b) Past COC-related	3		2		Yes
History of high blood pressure during pregnancy		2		1		Yes
History of pelvic surgery		1		1		Yes
HIV	High risk	1		1		Yes
	HIV infected (see also Drug Interactions)‡	1*		1*		Yes
	AIDS (see also Drug Interactions) ‡	1*		1*		Yes
	Clinically well on therapy	If on treatment, see Drug Interactions.				
Hyperlipidemias		2/3*		2*		Yes
Hypertension	a) Adequately controlled hypertension	3*		1*		Yes
	b) Elevated blood pressure levels (properly taken measurements)					
	(i) systolic 140-159 or diastolic 90-99	3		1		Yes
	(ii) systolic ≥160 or diastolic ≥100‡	4		2		Yes
	c) Vascular disease	4		2		Yes
Inflammatory bowel disease	(Ulcerative colitis, Crohn's disease)	2/3*		2		Yes
Ischemic heart disease‡	Current and history of	4		2	3	Yes
Liver tumors	a) Benign					
	i) Focal nodular hyperplasia	2		2		Yes
	ii) Hepatocellular adenoma‡	4		3		Yes
	b) Malignant‡	4		3		Yes
Malaria		1		1		Yes
Multiple risk factors for arterial cardiovascular disease	(such as older age, smoking, diabetes and hypertension)	3/4*		2*		Yes
Obesity	a) ≥30 kg/m² body mass index (BMI)	2		1		Yes
	b) Menarche to < 18 years and ≥ 30 kg/m² BMI	2		1		Yes
Ovarian cancer‡		1		1		Yes
Parity	a) Nulliparous	1		1		Yes
	b) Parous	1		1		Yes
Past ectopic pregnancy		1		2		Yes

Alphabetical Listing of USMEC Contraceptive Eligibility By Disease State

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Other Contraception Options Indicated for Patient
		Initiating	Continuing	Initiating	Continuing	
Pelvic inflammatory disease	a) Past, (assuming no current risk factors of STIs)					
	(i) with subsequent pregnancy	1		1		Yes
	(ii) without subsequent pregnancy	1		1		Yes
	b) Current	1		1		Yes
Peripartum cardiomyopathy‡	a) Normal or mildly impaired cardiac function					
	(i) < 6 months	4		1		Yes
	(ii) ≥ 6 months	3		1		Yes
	b) Moderately or severely impaired cardiac function	4		2		Yes
Postabortion	a) First trimester	1*		1*		Yes
	b) Second trimester	1*		1*		Yes
	c) Immediately post-septic abortion	1*		1*		Yes
Postpartum (see also Breastfeeding)	a) < 21 days	4		1		Yes
	b) 21 days to 42 days					
	(i) with other risk factors for VTE	3*		1		Yes
	(ii) without other risk factors for VTE	2		1		Yes
	c) > 42 days	1		1		Yes
Postpartum (in breastfeeding or non-breastfeeding women, including post-cesarean section)	a) < 10 minutes after delivery of the placenta					
	b) 10 minutes after delivery of the placenta to < 4 weeks					
	c) ≥ 4 weeks					
	d) Puerperal sepsis					
Pregnancy		NA*		NA*		NA*
Rheumatoid arthritis	a) On immunosuppressive therapy	2		1		Yes
	b) Not on immunosuppressive therapy	2		1		Yes
Schistosomiasis	a) Uncomplicated	1		1		Yes
	b) Fibrosis of the liver‡	1		1		Yes
Severe dysmenorrhea		1		1		Yes
Sexually transmitted infections (STIs)	a) Current purulent cervicitis or chlamydial infection or gonorrhea	1		1		Yes
	b) Other STIs (excluding HIV and hepatitis)	1		1		Yes
Sexually transmitted infections (cont.)	c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	1		1		Yes
	d) Increased risk of STIs	1		1		Yes
Smoking	a) Age < 35	2		1		Yes
	b) Age ≥ 35, < 15 cigarettes/day	3		1		Yes
	c) Age ≥ 35, ≥15 cigarettes/day	4		1		Yes
Solid organ transplantation‡	a) Complicated	4		2		Yes
	b) Uncomplicated	2*		2		Yes
Stroke‡	History of cerebrovascular accident	4		2	3	Yes
Superficial venous thrombosis	a) Varicose veins	1		1		Yes
	b) Superficial thrombophlebitis	2		1		Yes
Systemic lupus erythematosus‡	a) Positive (or unknown) antiphospholipid antibodies	4		3		Yes
	b) Severe thrombocytopenia	2		2		Yes
	c) Immunosuppressive treatment	2		2		Yes
	d) None of the above	2		2		Yes
Thrombogenic mutations‡		4*		2*		Yes

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Other Contraception Options Indicated for Patient
		Initiating	Continuing	Initiating	Continuing	
Thyroid disorders	Simple goiter/ hyperthyroid/hypothyroid.	1		1		Yes
Tuberculosis‡ (see also Drug Interactions)	a) Non-pelvic	1*		1*		Yes
	b) Pelvic	1*		1*		Yes
Unexplained vaginal bleeding	(suspicious for serious condition) before evaluation	2*		2*		Yes
Uterine fibroids		1		1		Yes
Valvular heart disease	a) Uncomplicated	2		1		Yes
	b) Complicated‡	4		1		Yes
Vaginal bleeding patterns	a) Irregular pattern without heavy bleeding	1		2		Yes
	b) Heavy or prolonged bleeding	1*		2*		Yes
Viral hepatitis	a) Acute or flare	3/4*	2	1		Yes
	b) Carrier/Chronic	1	1	1		Yes
Antiretroviral therapy (All other ARVs are 1 or 2 for all methods)	Fosamprenavir (FPV)	3*		2*		Yes
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3*		3*		Yes
	b) Lamotrigine	3*		1		Yes
Antimicrobial therapy	a) Broad spectrum antibiotics	1		1		Yes
	b) Antifungals	1		1		Yes
	c) Antiparasitics	1		1		Yes
	d) Rifampicin or rifabutin therapy	3*		3*		Yes
SSRIs		1		1		Yes
St. John's Wort		2		2		Yes

I = initiation of contraceptive method; C = continuation of contraceptive method; NA = Not applicable

* Please see the complete guidance for a clarification to this classification:
www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm

‡ Condition that exposes a woman to increased risk as a result of unintended pregnancy.

WPHCA

Serving Wisconsin Community Health Centers

July 12, 2023

To: Senate Committee on Health
From: Wisconsin Primary Health Care Association (WPHCA)

RE: In support of Senate Bill 211, Permitting pharmacists to prescribe certain contraceptives

Chair Cabral-Guevara and Committee Members,

The Wisconsin Primary Health Care Association (WPHCA), the member association for Wisconsin's 19 Federally Qualified Health Centers (Community Health Centers), shares support for Senate Bill 211, permitting pharmacists to prescribe certain contraceptives. We appreciate your consideration of the bill and urge the Committee to pass this important proposal which will increase access to essential care. In 2021, Wisconsin Community Health Centers served nearly 300,000 patients at 208 service delivery sites. The majority of patients served at Community Health Centers, 59%, are enrolled in the Medicaid program, 15% are uninsured, and 58% of patients earn at or below 100% of the Federal Poverty Level.

We urge you to pass SB 211 to increase access to contraceptive care for Wisconsinites. Community Health Centers often serve patients who have limited access to traditional health care systems for patients in both rural and urban areas. We see firsthand how limited hours of operation, transportation barriers, lack of affordable child care, and many other challenges pose barriers to establishing an ongoing primary care relationship. Many of the Community Health Centers WPHCA represents are doing their best to make care available across under-resourced areas, but may still have wait lists for appointments, especially for new patients. As policymakers, it is important to expand access to safe care that families need, and birth control is an essential component of that care.

Community-based pharmacists are well-suited to help meet that need, and most communities regardless of size have a pharmacy available. A 2021 analysis found that 9 out of every 10 Wisconsinites lives within a 10-minute drive of a pharmacy.[1] Pharmacists are highly educated providers trained to provide complex care, and prescribing certain contraceptives should be allowed for this skilled workforce. The bill also calls for patient protections including blood pressure checks and assessing for dangerous potential contraindications. We are especially appreciative of the consideration to connect with a patient's primary care provider and strengthen the coordination of care wherever possible.

This bill will improve access to important medications for individuals that may not have access to a medical care home and may reduce unintended pregnancies. WPHCA appreciates the leadership of Senator Felzkowski and the bipartisan group of over 40

WPHCA
Serving Wisconsin Community Health Centers

cosponsors. Please contact Richelle Andrae, WPHCA Government Relations Specialist, with any questions, at randrae@wphca.org.

Sincerely,

Richelle Andrae

Richelle Andrae
Government Relations Specialist
Wisconsin Primary Health Care Association
randrae@wphca.org
(608) 571-6168

[1] Illustrating access to community pharmacies in Wisconsin - ScienceDirect

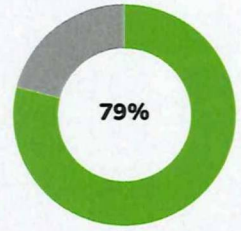
WHAT IS A COMMUNITY HEALTH CENTER?

January 2023

There are 19 federally-designated Community Health Centers in Wisconsin with more than 200 service delivery sites, serving nearly 300,000 patients.

DID YOU KNOW?

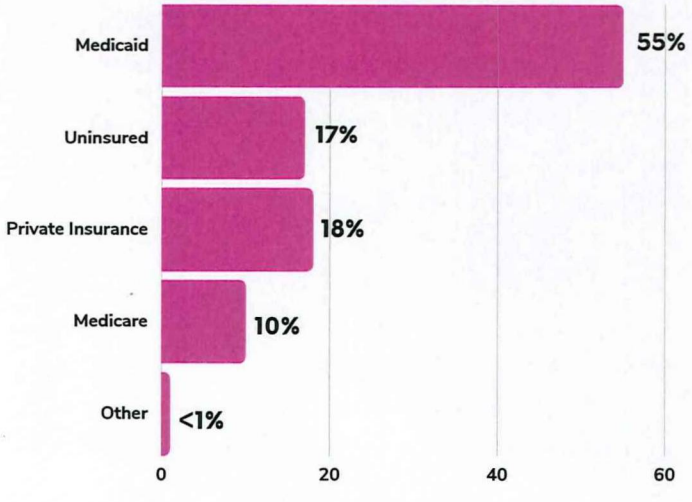
- Community Health Centers are clinics that provide **primary care services, including check-ups, behavioral health, dental care, substance use disorder treatment,** and enabling services like care coordination and community referrals.
- Wisconsin's 19 Community Health Centers are part of a national network of clinics that serve as the medical home for over **29 million people** of all ages in over 12,000 communities.
- Community Health Centers provide services to everyone **regardless of insurance status,** with fees adjusted based on a patient's ability to pay.
- Because of their special federal designation, Community Health Centers participate in unique programs like the **National Health Service Corps,** a program to place providers in areas without enough providers to serve the population.
- Community Health Centers receive **limited funding from public investments** to provide care for uninsured individuals and high-need populations (approximately one-third of revenue is state or federal grant funding).
- Every $1 in federal investments generates $7 in economic activity across Wisconsin, delivering over **$652 million in economic activity annually.**



79% of Community Health Center patients live below 200% of the Federal Poverty Line.

The Federal Poverty Line in 2021 is $26,500 for a family of four.

Insurance Status of Wisconsin Community Health Center Patients



WHAT MAKES COMMUNITY HEALTH CENTERS UNIQUE?

Community Health Centers are:

- Dedicated to filling gaps in traditional health care systems by serving under-resourced communities
- Private or public not-for-profit organizations
- Located in or serving high need communities, based on federal requirements, which may be urban or rural areas
- Governed by a patient-majority Board of Directors
- Responsible for meeting performance and accountability requirements and publicly reporting clinical and financial data to the federal government

Community Health Centers sit at the crossroads of health care and public health. They are not:

- Hospitals or health systems
- Free and charitable clinics
- Local public health departments

Richelle Andrae
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TESTIMONY IN OPPOSITION TO SENATE BILL 211
SENATE COMMITTEE ON HEALTH
WEDNESDAY, JULY 12, 2023
JACK HOOGENDYK, LEGISLATIVE & POLICY DIRECTOR

Thank you, Chairman Cabral-Guevara and committee members, for the opportunity to testify on Senate Bill 211. 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 can happen when a contraceptive drug or device 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, get married, and then have children. Putting funding in the budget for the promotion of this sequence will have a far greater impact on poverty—especially generational poverty—than will allowing pharmacists to prescribe contraceptive devices and drugs. The argument supporters are making is specious, at best.

Allowing pharmacists to prescribe and dispense contraception, at least to some degree, will encourage unmarried individuals to engage in sexual activity. There is an argument that individuals will get contraceptives somewhere, and it may as well be from a pharmacist who cannot perform an abortion, but that argument 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, she will find a place to obtain her abortion, if that is what she intends to do.

We find it more than interesting that this bill never uses the word *woman*, but rather uses *person* (p.3, 21) and *patient* (throughout the bill). As we know, men do not use the kind of contraceptives this bill addresses. Yet, the wording of the bill appears to allow a man to go through the process and get a prescription for a contraceptive drug or device. For what purpose might that be? We know pimps and johns are concerned that their "girls" do not get pregnant. This bill seems to open the door for these individuals to easily get contraceptives. Admittedly, the bill says a pharmacist "***may*** prescribe and dispense" (p.3, l. 17). (Emphasis added.) However, nothing in the bill clearly prevents the above scenario from happening.

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 referenced earlier.

Scientifically and medically, 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 patient" must complete "a self-assessment questionnaire and undergo a blood pressure screening," and added for the first time in Senate Bill 211, "the patient" must also "acknowledge on the self-administered questionnaire" that the contraception does not protect against sexually transmitted diseases and that "it" recommends that "the patient" annually meet with a medical professional to discuss "the patient's" contraceptive prescriptions. Based on the very limited information available to the pharmacist, 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. During a public hearing when this bill was first introduced several sessions ago, 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 we followed up with our testimony and addressed this issue, a committee member responded by saying, "You know we frequently pass bills where we don't know who is liable." We 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.

Senate Bill 211, unlike previous iterations of the bill, also expands who may "provide" the self-administered questionnaire" and may "administer a blood pressure screening," to include "any qualified pharmacy employee." The bill indicates the prescription may be prescribed and dispensed as long as a pharmacist reviews the results of the questionnaire and blood pressure screening. We would be interested in knowing if the participation of the "qualified pharmacy employee" makes this employee potentially liable as noted above.

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. With the addition of "any qualified pharmacy employee," this potential violation of religious or conscience rights seems to be expanded.

I would like to read a short statement from a board-certified Ob-Gyn, expressing her concerns with this bill.

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.

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TESTIMONY IN OPPOSITION TO SENATE BILL 211
SENATE COMMITTEE ON HEALTH
WEDNESDAY JULY 12, 2023

Statement from Patti Giebink, MD, Ob-Gyn

I respect and rely on pharmacists and their knowledge about medications. However, it is the medical doctors and practitioners that need to see women annually for pap smears, STD testing, annual exams and BP checks to prevent and treat problems common to women.

Pap smears and HPV testing cannot be done in the pharmacy. Even though pharmacists can ask questions and give some instructions, most women seeking hormonal contraception need someone educated in the practicalities of hormones and their effect on the body as well as risk assessment and screening. Most women require some modification or change of pills when side effects like break through bleeding occur. Medical clinics have protocols for Pap smears, reminders and follow-up.

It would be a blow to women's health care to interfere with this regular health maintenance.

Dr. Patricia Giebink is an obstetrician-gynecologist in Chamberlain, South Dakota. She received her medical degree from University of South Dakota School of Medicine and has been in practice for more than 30 years.

She is the author of the book "Unexpected Choice" about her experiences as an Ob-Gyn. She has also written several articles in national health publications.

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

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.

New Study Links Oral Contraceptives and Depression

The Cambridge University Press just published one month ago, (June 12, 2023) a major study on the effects of oral contraceptives on women. According to the study, women who began to use contraceptive pills as teenagers had a 130 per cent higher incidence of symptoms of depression, while the corresponding increase among adult users was 92 per cent.

"The powerful influence of contraceptive pills on teenagers can be ascribed to the hormonal changes caused by puberty. As women in that age group have already experienced substantial hormonal changes, they can be more receptive not only to hormonal changes but also to other life experiences," Johansson says.[1]

Our findings suggest that the use of OCs, particularly during the first 2 years, increases the risk of depression. Additionally, OC use during adolescence might increase the risk of depression later in life. Our results are consistent with a causal relationship between OC use and depression, as supported by the sibling analysis. This study highlights the importance of considering the healthy user bias as well as family-level confounding in studies of OC use and mental health outcomes. Physicians and patients should be aware of this potential risk when considering OCs, and individualized risk–benefit assessments should be conducted.[2]

A recent study published in *Epidemiology and Psychiatric Sciences* found that women using birth control pills may have as much as 130% increased risk for depression, particularly in the first two years of oral contraceptive use.[3]

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[1] New study links contraceptive pills and depression -- ScienceDaily

[2] Population-based cohort study of oral contraceptive use and risk of depression | Epidemiology and Psychiatric Sciences | Cambridge Core

[3] Depression: Birth control pills may raise risk by 130% (medicalnewstoday.com)

Testimony in Opposition to Assembly Bill 176/Senate Bill 211: permitting pharmacists to prescribe certain contraceptives
Senate Committee on Health
By Matt Sande, Director of Legislation

July 12, 2023

Good afternoon, Chairwoman Cabral-Guevara 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) 176 and Senate Bill (SB) 211, companion legislation permitting pharmacists to prescribe hormonal contraceptive patches (the Patch) and self-administered oral hormonal contraceptives (the Pill) to persons who are at least 18 years of age.

Studies demonstrate that the 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 176/SB 211 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 package label indicates that it can work to prevent a fertilized egg (a human embryo) from implanting in the uterine wall:

Mechanism of Action: Combined oral contraceptives (COCs) lower the risk of becoming pregnant primarily by suppressing ovulation. Other possible mechanisms may include cervical mucus changes that inhibit sperm penetration and the ***endometrial changes that reduce the likelihood of implantation****. (Wyeth Pharmaceuticals Inc. LAB-1123-1.0 Revised October 2017)*

The Physicians' Desk Reference also indicates that LO/OVRAL-28 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).*

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.***

*Web*MD also describes the pharmacological action of the transdermal patch:

The patch keeps you from getting pregnant by sending the hormones estrogen and progestin through your skin and into your bloodstream. The hormones keep your ovaries from releasing an egg, thicken the cervical mucus to stop 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 embryo implantation 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 the word "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. **It is not the proper role of the pharmacist to diagnose health conditions and prescribe powerful medications with clear health risks.**

On October 22, 2021, the Wisconsin State Journal ran a story on Wisconsin's unemployment rate. In the story,

*"DWD officials said Wisconsin employers continue to struggle to fill jobs due to a workforce gap driven by **low birthrates**, high retirement rates and low net migration and immigration flows into the state…'The labor force may decline by 2035, rather than just be flat,' said Scott Hodek, section chief of DWD's Office of Economic Advisors. 'This is essentially the retirement of the*

baby boomer generation. As that generation ages and in turn ages out of the labor force, it becomes more and more difficult to replace those job openings.'"

At a time when state government should be developing and promoting policies that incentivize natural population growth, why would the bill authors attempt to do the opposite by pushing wide and easy access to contraceptives?

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 176/SB 211 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.

ACOG
The American College of Obstetricians and Gynecologists Wisconsin Section

To: Senate Committee on Health
From: Dr. Amy Domeyer-Klenske, MD
Date: July 12, 2023
Re: Senate Bill 211

Chairwoman Cabral-Guevara and members of the Committee, thank you for the opportunity to provide testimony in support of Senate Bill 211.

My name is Dr. Amy Domeyer-Klenske, MD. I submit this testimony in my capacity as a member of the Wisconsin Section of the American College of Obstetricians and Gynecologists (WI-ACOG), as well as a physician affiliated with the University of Wisconsin School of Medicine and Public Health where I am an Associate Professor and Director of the Division of Academic Specialists in Obstetrics and Gynecology. I practice general obstetrics and gynecology in the outpatient and inpatient settings. My clinical work includes provision of contraception and I daily assist patients in decision-making around reproductive health and contraception. As such, I am uniquely qualified to speak on behalf of my patients, the women of Wisconsin.

Nearly all U.S. women who have ever had sexual intercourse have used some form of contraception at some point during their reproductive lives. The American College of Obstetricians and Gynecologists (ACOG) has long supported[1] over-the-counter access to oral contraceptives and over-the-counter access to vaginal rings, the contraceptive patch, and depot medroxyprogesterone acetate (DMPA) injections, which is a status only the U.S. Food and Drug Administration (FDA) can confer. Recognizing that women want as many options as possible to manage their reproductive health, ACOG also supports pharmacist-provided contraception, identifying it as a necessary intermediate step to achieve over-the-counter access to hormonal contraception.[2]

The **benefits** of contraception are widely recognized and include improved health and wellbeing, reduced global maternal mortality, health benefits of pregnancy spacing for maternal and child health, female engagement in the work force, and economic self-sufficiency for women. Importantly, contraception is essential to preventing the numerous health risks incurred by

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[1] https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/10/over-the-counter-access-to-hormonal-contraception

[2] https://www.acog.org/news/news-releases/2019/09/acog-updates-guidance-on-over-the-counter-access-to-hormonal-contraception

pregnancy. Many contraceptive methods also offer non-contraceptive health benefits, such as decreased menstrual bleeding and pain as well as reduced incidence of gynecologic disorders, including a lower lifetime risk of endometrial and ovarian cancer.

Increasing access to consistent, effective, and affordable contraception is also one of the most important and effective ways to reduce unwanted or unintended pregnancy and abortion. Barriers that prevent women from obtaining contraceptives or from using them consistently and effectively contribute to inconsistent or nonuse of contraception and rates of unintended or unwanted pregnancy. Requiring a prescription to access contraception poses a significant obstacle for many people who wish to avoid pregnancy. In one national survey[3] of 1,385 women at risk of unintended pregnancy, 68% reported ever having tried to obtain a prescription for hormonal contraception. Of those, a full 29% reported encountering problems accessing either the initial prescription or prescription refills.

Reported obstacles included:

- Cost barriers or lack of insurance (14%).
- Challenges in obtaining an appointment or getting to a clinic (13%).
- The health care provider requiring a clinic visit, examination, or Pap test (13%).
- Not having a regular physician or clinic (10%).
- Difficulty accessing a pharmacy (4%)

Put another way, nearly 1/3 of these women had been given a prescription for contraception and yet they STILL couldn't access it.

All women should have unhindered and affordable access to all U.S FDA- approved contraceptives. Access to pharmacist-provided contraception should include access to all hormonal contraception including vaginal rings, the contraceptive patch, and depot medroxyprogesterone acetate (DMPA) injections (also known as Depo shots) and should not be limited by age restrictions. Legislation should also protect women from incurring new out-of-pocket costs and ensure that contraceptives dispensed by pharmacists remain covered by insurance.

Finally, facts are important when discussing health care. Promulgating inaccurate information and misconceptions about how contraceptives work does not serve the interests of women and

[3] https://pubmed.ncbi.nlm.nih.gov/26666711/

others who wish to avoid pregnancy. While beliefs about what constitutes the beginning of life may well vary across individuals and cultures, the medical community defines pregnancy as beginning at implantation. All FDA-approved contraceptive methods, including emergency contraception and intrauterine devices (IUDs), work to prevent pregnancy either by preventing fertilization of an egg or by preventing implantation of a fertilized egg. Indeed, ACOG specifies that "contraceptives that prevent fertilization from occurring, or even prevent implantation, are simply not abortifacients regardless of an individuals' personal or religious beliefs or morals."[4]

In closing, I want you to remember that FDA-approved hormonal contraception is safe, efficacious, and cost-effective. These contraceptive methods help women avoid unwanted pregnancies. They do not cause abortions. They do prevent cancer, treat pain, help lift women and families out of poverty, and allow individuals to avoid the health risks and other costs associated with pregnancy.

Chairwoman and members of the Committee, Senate Bill 211 is your opportunity to remove barriers for women who want to manage their own reproductive health with hormonal contraception. Thank you for your consideration.

[4] http://sblog.s3.amazonaws.com/wp-content/uploads/2013/10/13-354-BRIEF-OF-AMICI-CURIAE-PHYSICIANS-FOR-REPRODUCTIVE-HEALTH-et-al....pdf

Pharmacy Society of Wisconsin

To: Members, Senate Committee on Health

From: Danielle Womack, MPH
Vice President, Public Affairs, Pharmacy Society of Wisconsin

Date: July 12, 2023

Subject: Support for Assembly Bill 176 / Senate Bill 211

Thank you for the opportunity to provide testimony supporting Assembly Bill 176/Senate Bill 211, which would allow pharmacists to prescribe oral and patch contraceptives to patients aged 18 and older. On behalf of the Pharmacy Society of Wisconsin, I would like to share support for this legislation to increase access to contraception as has been done in twenty-seven other states[1].

AB 176/SB 211 would allow a pharmacist to prescribe and dispense self-administered oral hormonal contraceptives and hormonal contraceptive patches. By allowing pharmacists to perform this task, pharmacists will be able to bridge gaps in patient access to health care. Healthcare access issues are seen throughout the state by provider shortages, long distances to clinics, long wait times for appointments, and limited hours during the workday. Legislation that allows for pharmacist-prescribed contraception will increase patient access to these services; for example, patients who are unable to go to their clinic during the workday due to taking time off or finding childcare during their appointment time would greatly benefit from increased access to medications in community pharmacies. One study showed that 74% of women seeking contraception from their pharmacist chose the pharmacy because they could access a pharmacist sooner than their primary care provider.[2]

This bill helps to protect patients by putting specific processes in place to ensure that patients are appropriately screened and approved for these medications. In most other states that allow pharmacists to prescribe birth control independently, a patient must have a self-screening questionnaire asking about blood pressure measurement, medical and medication history, pregnancy history and status, and smoking history. After completing the screening process, the pharmacist will use their expertise to determine whether to prescribe and dispense medication for contraception. Additionally, if a pharmacist prescribes and dispenses birth control, the pharmacist must inform the patient's primary care provider. AB 176/SB 211 follows the above-stated safety requirements and other jurisdictions' precedents.

Others have raised concerns that it is not safe for a pharmacist to prescribe contraceptive products. I would disagree by citing that overwhelmingly, major medical groups – including the

[1] Arizona, Arkansas, California, Colorado, Delaware, Hawaii, Idaho, Illinois, Indiana, Maryland, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oregon, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia.

[2] Sally Rafie, Alexandra Wollum, and Kate Grindlay, "Patient Experiences with Pharmacist Prescribed Hormonal Contraception in California Independent and Chain Pharmacies," Journal of the American Pharmacists Association 62 (1) (2022): 378–386.

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American College of Obstetricians and Gynecology, the American Medical Association, and the American Academy of Family Physicians – support over-the-counter access to contraceptives and believe they are safe enough for patients to purchase without any prescription whatsoever. An article from the American College of Obstetricians and Gynecology states:

> *"Despite the safety of OC use, one frequently cited concern regarding over-the-counter provision of OCs is the potential harm that could result if women with contraindications use them. However, several studies have shown that women can self-screen for contraindications. In one study that compared current family planning clients' self-assessment of contraindications with clinical assessment, 392 of the 399 participant (females aged 15–45 years) and health care provider pairs obtained agreement on medical eligibility criteria (greater than 90%) ... A study conducted in the United Kingdom replicated the findings that women take a more conservative approach compared with clinicians and also demonstrated that none of the 328 women studied would have incorrectly used OCs based on self-screening. Another study found that women obtaining OCs from pharmacies were no more likely to have contraindications than those who got OCs from a clinic."*[3]

A study from Oregon Health & Sciences University found that women obtaining oral contraceptives online without a physical exam were no more likely to have contraindications than those who got a prescription from their physician[4]. A study from the University of Washington concluded that "pharmacists can efficiently screen women for safe use of hormonal contraceptives and select appropriate products."[5] Lastly, a study published in the Journal of Family Planning and Reproductive Health Care concluded, "A self-completed history questionnaire is acceptable to women and can potentially replace traditional routine medical history taking for continuing hormonal contraception. Women completed the questionnaire with a high degree of reliability," and "Overall, clients reported more risk factors than clinicians, which increases the safety of the questionnaire."[6]

Pharmacists in the community have an essential role in providing increased access to care amid a primary care shortage. Because pharmacies tend to have longer hours than clinics, are open on weekends, and don't usually require an appointment to see a pharmacist, patients have more opportunities for care compared to the limited hours of a clinic. Two years after Oregon implemented the ability for pharmacists to prescribe contraception, the policy prevented an estimated 51 unintended pregnancies and saved the state $1.6 million.[7] Pharmacists are highly trained in pharmacotherapy and genuinely are the medication experts on the healthcare team. Pharmacists can ease the burden on physicians and provider counterparts while improving contraceptive access.

Thank you for taking the time to consider my testimony. I am happy to answer any questions from the committee.

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[3] "Committee Opinion No. 544." *Obstetrics & Gynecology* 120, no. 6 (2012): 1527–31. http://ocsotc.org/wp-content/uploads/2012/12/ACOG-2012_OTC-Access-to-Oral-Contraceptives.pdf.

[4]Kaskowitz, Alexa P., Nichole Carlson, Mark Nichols, Alison Edelman, and Jeffrey Jensen. "Online Availability of Hormonal Contraceptives without a Health Care Examination: Effect of Knowledge and Health Care Screening." *Contraception* 76, no. 4 (2007): 273–77. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2706829/.

[5]Gardner, Jacqueline S., Donald F. Downing, David Blough, Leslie Miller, Stephanie Le, and Solmaz Shotorbani. "Pharmacist Prescribing of Hormonal Contraceptives: Results of the Direct Access Study." *Journal of the American Pharmacists Association* 48, no. 2 (2008): 212–26. https://www.ncbi.nlm.nih.gov/pubmed/18359734.

[6] Doshi, J. S., R. S. French, H. E. R. Evans, and C. L. Wilkinson. "Feasibility of a Self-Completed History Questionnaire in Women Requesting Repeat Combined Hormonal Contraception." *Journal of Family Planning and Reproductive Health Care* 34, no. 1 (January 2008): 51–54. https://www.ncbi.nlm.nih.gov/pubmed/18201408.

[7] Maria Rodriguez and others, "Association of Pharmacist Prescription of Hormonal Contraception with Unintended Pregnancies and Medicaid Costs," Obstetrics and Gynecology 133 (6) (2019): 1238–1246.

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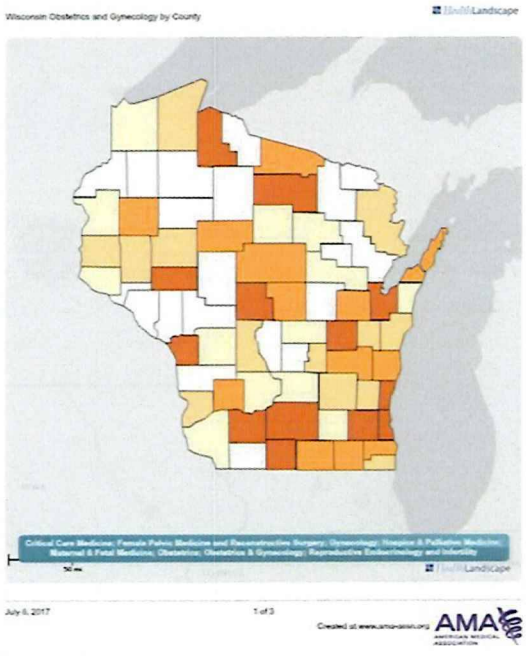
Senate Committee on Health
Testimony in Support of Assembly Bill 176 & Senate Bill 211
Submitted by Ellen Hartenbach, MD
Chair, Department of Obstetrics/Gynecology
July 12, 2023

Dear Chairperson Cabral-Guevara and members of the committee:

Thank you for this opportunity to share my support for Assembly Bill 176 and Senate Bill 211 (AB176/SB211) as introduced by Rep. Joel Kitchens and Sen. Mary Felzkowski. 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. I have been working in the field of medicine for more than 25 years and have contributed to more than 80 peer-reviewed journal articles and co-authored two book chapters. To say I am passionate about women's health care is an understatement. I am sorry I can't be there in-person to share my passion for this issue but I hope you consider the following.

In my practice, 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 AB176/SB211 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 20 of Wisconsin's 72 counties have no OB/GYN 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 at least a dozen states.

As you explore the implications of the proposed public policy, I'll leave you with one final thought – that being the potential savings this bill could bring to the Wisconsin Medicaid program. As evidence of that potential savings, we can look to Oregon whose legislature passed a

similar law in 2016. Research following passage found the law prevented an estimated 51 unintended pregnancies and saved an estimated $1.6 million in associated taxpayer costs in the first two years, according to a study published in June 2019 by *Obstetrics & Gynecology* (1). That's another example of public policy that is in my opinion, headed in the right direction.

For the reasons I have outlined above, I hope you see fit to join me in supporting AB176/SB211. Thank you for your consideration. Please contact Connie Schulze if you'd like to discuss any aspect of my testimony and she'll assist in connecting us.

1. Association of Pharmacist Prescription of Hormonal Contraception With Unintended Pregnancies and Medicaid Costs
   Rodriguez, Maria I. MD, MPH; Hersh, Alyssa MPH; Anderson, Lorinda B. PharmD; Hartung, Daniel M. Pharm D, MPH; Edelman, Alison B. MD, MPH *Obstetrics & Gynecology* 133(6):p 1238-1246, June 2019. | *DOI:* 10.1097/AOG.0000000000003265