JOEL KITCHENS
STATE REPRESENTATIVE • 1ST ASSEMBLY DISTRICT

Testimony for the Assembly Committee on Health, Aging, and Long-Term Care

Assembly Bill 43

April 23, 2025

Thank you Chairman Moses and committee members for holding a public hearing and allowing me to testify on Assembly Bill 43, 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.

Currently, women can get Opill (norgestrel) over-the-counter. It contains a type of hormone called a progestin that helps prevent pregnancy. The key word there is "helps." While Opill is very safe, it is not as effective as other birth control medications.

Our bill would, under specific circumstances, allow a woman who is 18 or older, 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

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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.

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 20's 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. When they enter school, these youth score worse on average 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

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reason 10 percent of women drop out of community college and most never obtain their degree. This perpetuates the intergenerational cycle of poverty.

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

When the common birth control pill became available in the United States in the 1960s, you could only obtain oral contraceptives through a prescription from a doctor. That made sense at the time, particularly since the pills had 20 times the hormone levels that they have now. Experts were not sure how the medication would affect women physiologically.

Fast-forward 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

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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 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 their moral convictions. If they 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. Instead of sticking to moral arguments, they put out misinformation attacking safety & efficacy.

We all know what you will hear today. Groups will throw everything at the wall, hoping something will stick. 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, and they also twist science to justify their moral position.

When used consistently and correctly, oral contraceptives are 99.9% effective. You will hear false and misleading statements from the bill's opponents, but the reality is that 95% of unplanned pregnancies are attributed to the one-third of women who do not use contraceptives or use them inconsistently.

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

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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.

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 actually increases the number of unplanned pregnancies and abortions in our state and country.

According to a 2018 report from the Centers for Disease Control, unintended pregnancy is the major contributor to induced 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.

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 29 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 Democratic issue. Most of the states that have 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 Assembly Bill 43 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.

The vast, vast majority of sexually active women in the U.S. use hormonal birth control or have used it in the past. This bill will not increase that percentage appreciably. What

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it will do is make it more easily accessible, so that they can use it consistently and effectively.

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 now happy to answer any questions you have.

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RACHAEL A. CABRAL-GUEVARA

STATE SENATOR • 19TH SENATE DISTRICT

Testimony before the Assembly Committee on Health, Aging, and Long-Term Care

Senator Rachael Cabral-Guevara

April 23, 2025

Hello, members of the Assembly Committee on Health, Aging, and Long-Term Care. Thank you for allowing me to provide testimony on Assembly Bill 43, a proposal that will help improve health care access in Wisconsin.

Wisconsin is facing a severe health care access crisis. This includes some folks having to drive hours to see their primary care provider, which can hinder the ability to be prescribed medications that may be needed for a variety of reasons. This is certainly true of contraceptive medications, which can be used as both a form of birth control and help with a variety of issues related to the menstrual cycle.

At least twenty-nine states, including the District of Columbia, allow pharmacists to provide contraception without a doctor's prescription. This includes a list of states ranging from Utah to New York. Beyond that, over-the-counter birth control pills became available in 2024 at pharmacies and stores around the United States.

This bill intends to have Wisconsin join the majority of states that allow pharmacists to prescribe birth control. As you may hear today, side effects can be a risk as with any medication. That is why this bill also requires an assessment to be conducted before the dispensing of any prescribed contraceptive drug, which is not needed for over-the-counter pills. Though I would note, as a prescriber, I have seen more patients come in to my clinic with adverse side effects from dietary supplements or Tylenol than I have from contraceptives.

By allowing pharmacists the ability to prescribe birth control, we can help in two key ways: boosting access to commonly prescribed medication and improving outcomes for women who need to use these medications for a variety of reasons. Anything we can do to reduce barriers in what are becoming increasingly large health care deserts is a welcome step in the right direction.

I am hopeful you will support this simple step in the right direction to help improve access and outcomes for women across Wisconsin. Thank you for your time.

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To: Members, Assembly Committee on Health, Aging, and Long-Term Care
From: Jacob Deheck, DPH-4
Date: April 23rd, 2025
Subject: Testimony in Support of Assembly Bill 43

Good morning, Chairman Moses and Members of the Committee. Thank you for the opportunity to speak today. My name is Jacob Deheck, and I'm a fourth-year Doctor of Pharmacy Student. In this final year of the program, my time has been fully dedicated to clinical rotations across the Madison area, from community pharmacies to hospital systems and ambulatory care clinics, and I've seen firsthand both the power of pharmacy and the barriers our fellow Wisconsinites face.

Assembly Bill 43 is about meeting patients where they are, especially in underserved and rural communities where access to healthcare providers is limited. I grew up in a rural area of Wisconsin and am very familiar with challenges in accessing timely primary care. Pharmacists are some of the most accessible healthcare professionals due to their proximity to the community and broad expertise. We're trained in medication management, chronic disease support, and immunization delivery, with opportunities like Bill 43 allowing further practice within our scope of expertise.

This bill would support pharmacists doing what we are already trained to do, help people live healthier, safer lives. I've had patients come from clinics with prescriptions and no clear idea how to take them. I've watched as people delay care because they can't get in to see their doctor for months. And I've seen the difference it makes when a pharmacist is empowered to step in, answer questions, adjust therapy under protocol, and act as a facilitator in communication between patients and providers whenever necessary, as outlined in this bill.

Assembly Bill 43 is a step toward a more connected, efficient, and accessible healthcare system. It supports collaboration between pharmacists and other providers to prevent lapses in care because, most importantly, it puts patients first.

We urge you to support this bill — not just for those of us entering the profession, but for the thousands of Wisconsinites who rely on pharmacists every day.

Thank you for your time and your commitment to improving healthcare in our state.

Pharmacy Society of Wisconsin

To: Members, Assembly Committee on Health, Aging, and Long-Term Care

From: Danielle Womack, MPH, HIVPCP
Vice President, Public Policy & Advocacy, Pharmacy Society of Wisconsin

Date: April 23, 2025

Subject: Support for Assembly Bill 43

Thank you for the opportunity to provide testimony supporting Assembly Bill 43, 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 thirty other states[1].

AB 43 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 43 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 American College of Obstetricians and Gynecology, the American Medical Association, and the

[1] Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Maine, Maryland, Massachusetts, 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 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.

To: Members, Assembly Committee on Health, Aging, and Long-Term Care
From: Lexi Wery, PharmD Candidate 2027
Date: April 23rd, 2025
Subject: Testimony in Support of Assembly Bill 43

Members of the Committee, thank you very much for your time today and allowing me to provide testimony in favor of Assembly Bill 43, which would authorize pharmacists to prescribe oral and patch contraceptives. My name is Lexi Wery, and I am in my second year of pharmacy school. Upon graduation and becoming a licensed pharmacist, I look forward to returning to my rural hometown of Brussels, Wisconsin, and providing care to many familiar faces. I aspire to be the pharmacist who knows my patients by name, who recognizes their voice on the phone, who understands their history not just from a chart, but from years of trust and connection. I believe in the power of those relationships and how they impact a patient to feel comfortable asking questions, sharing concerns, and seeking guidance because they know I genuinely care. This kind of care can't be rushed or outsourced; it's built over time with consistency, presence, and compassion.

This legislation would give me the opportunity to serve my community in a deeper, more meaningful way. It's not just about expanding a pharmacist's role. It's more about meeting patients where they are and providing timely, essential healthcare in areas where access is limited. Growing up in a rural community, I saw firsthand how challenging it can be for people to access even the most basic care. And now, as a young adult navigating the healthcare system myself, I've personally experienced how fragmented and inconsistent that care can be, especially when it comes to something as fundamental as having a primary care provider.

In just the last five years, I have had to change my primary care provider twice. Not because I moved far away or changed insurance plans but simply because providers left or practices changed, and I had no choice but to start over. Each time, it meant scheduling appointments months in advance and rebuilding trust with a new provider. I know I'm not alone when I say this experience is frustrating and exhausting. This kind of instability is even more common in rural areas, where provider shortages are persistent and growing.

That's why I feel so strongly about this bill. Pharmacists are among the most accessible and trusted healthcare professionals. We're in grocery stores, on main streets, and in small towns where no other provider may be available for miles. We're already trained to assess medical history, counsel on medication use, and recognize when a referral to another provider is needed.

This bill has the power to make real, measurable change for women in Wisconsin, especially in rural areas like mine. For someone who can't take time off work to drive an hour to the nearest clinic or who's in between providers like I've been, the ability to walk into a local pharmacy and talk to a knowledgeable, licensed professional about birth control could be life-changing.

As a future pharmacist, I want to return to my community not just to dispense medication but to be a frontline healthcare provider who fills in the gaps that, right now, leave too many people without options. This bill would enable pharmacists like me to do exactly that: to offer timely, compassionate, and comprehensive care when and where it's needed most.

But today, as a student pharmacist, I feel honored and deeply passionate to be here standing at the intersection of learning and leading. I represent not just myself but the future of the pharmacy profession. My current pharmacy education is focused on training us to practice at the top of our license, to be collaborative members of the healthcare team, and to solve the kinds of access issues this bill directly addresses. My colleagues and I are ready and willing to meet patients' needs with skill, empathy, and responsibility.

I see a future in which pharmacists are empowered to do more, to serve more, and to make a larger impact in our communities. That future starts with this bill. My classmates and I are not just studying for a profession. We are preparing to step into roles that will shape the future of healthcare in this state. Giving us the tools and authority to provide care when and where it's needed most is not only good policy—it's an investment in that future.

Thank you again for the opportunity to provide testimony in favor of Assembly Bill 43. We welcome any questions that you may have.

Testimony in Opposition to Assembly Bill 43: permitting pharmacists to prescribe certain contraceptives
Assembly Committee on Health, Aging and Long-Term Care
By Matt Sande, Director of Legislation

April 23, 2025

Good morning, Chairman Moses 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) 43, 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 43 is the abortifacient effect of hormonal contraceptives. It is a medical fact that the morning-after pill (a high dosage of the birth control

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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.

The American College of Obstetricians and Gynecologists (ACOG) indicates that progestin-only pills can work to prevent a fertilized egg (a human embryo) from implanting in the uterine wall:

> *The progestin in the pills has several effects in the body that help prevent pregnancy:*
> - *The mucus in the cervix thickens, making it difficult for sperm to enter the uterus and fertilize an egg.*
> - *Progestin stops ovulation, but it does not do so consistently. About 4 in 10 women who use progestin-only pills will continue to ovulate.*
> - ***Progestin thins the lining of the uterus.***
>
> https://www.acog.org/womens-health/faqs/progestin-only-hormonal-birth-control-pill-and-injection#:~:text=How%20do%20progestin%2Donly%20pills,does%20not%20do%20so%20consistently

And according to *Web*MD,

> *Hormonal contraceptives (the pill, the patch, and the vaginal ring) all contain a small amount of hormones. These hormones inhibit your body's natural hormones to prevent pregnancy in a few ways. Hormonal contraceptives usually stop your body from ovulating. They also change the cervical mucus to make it difficult for the sperm to go through the cervix and find an egg.* ***They can also prevent pregnancy by changing the lining of the womb so it's unlikely the fertilized egg will be implanted.***
>
> https://www.webmd.com/sex/birth-control/birth-control-pills

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

> *The patch contains the same hormones as the combined pill and works in the same way. The patch prevents pregnancy by releasing hormones which:*
> - *prevents you from releasing an egg (ovulating)*
> - *makes it difficult for sperm to get to an egg*
> - ***thins the womb lining, so there's less chance an egg will attach to it***
>
> https://www.nhsinform.scot/healthy-living/contraception/contraceptive-patch/

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

> *How Does the Birth Control Patch Work? 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 slow down the movement of sperm, and* ***make it harder for any fertilized egg to implant inside your womb.***
>
> https://www.webmd.com/sex/birth-control/birth-control-transdermal-patches

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 January 27, 2025, Wisconsin Public Radio (WPR) ran a story on Wisconsin's rapidly declining population. In the story,

> "A new projection from the state found Wisconsin's population is expected to decline by nearly 200,000 residents by 2050. That's largely due to declining birth rates and the aging of baby boomers, according to a Wisconsin Department of Administration report. [...] John Johnson, a researcher at Marquette University Law School, called the projection 'sobering.' 'Anyone who's looked at birth statistics knows that people in Wisconsin are having fewer and fewer babies, and we're not a hot spot for migration,' Johnson told WPR."
>
> https://www.wpr.org/news/wisconsin-population-decline-nearly-200k-residents-2050

At a time when state government should be developing and promoting policies that incentivize natural population growth, why would the bill authors 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 43 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.

WISCONSIN CATHOLIC MEDICAL GUILDS

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

April 23, 2025

To: Members, Assembly Committee on Health, Aging and Long-Term Care

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

RE: AB 43 – permitting pharmacists to prescribe certain contraceptives

Good morning, Chairman Moses 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) 43 and strongly urges you to not pass this bill out of committee.

As you know, AB 43 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 43 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
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
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.

AMANDA NEDWESKI
STATE REPRESENTATIVE • 32ND ASSEMBLY DISTRICT

Testimony – Assembly Bill 43

April 23, 2025

Thank you, Chairman Moses and committee members, for holding this hearing today. I am here to share the story of Emily, whose story I came to know since last session, when I first signed on in support of this bill.

Emily grew up as the oldest of 5 in a small town in northern Wisconsin. Mom worked at a nearby mill during the day and waited tables at night. During the recession, the family lost their farm, and her father tragically took his own life. She often had no choice but to be the second parent in the home while her mother worked around the clock to make ends meet. Being accepted to UW-Madison was one of her proudest moments, but Emily ultimately opted not to attend college because her mother needed her help raising her brothers and sisters. After losing Dad, she chose to find joy in her family every single day, and she rejoiced in her commitment to them.

While running the office for a local equipment dealer, she met Sam, and the two fell in love and married. Though she sometimes regretted foregoing college, she knew that Sam had come into her life for a reason, and she dreamed of the day when they would be financially stable enough to start a family of their own. Watching her mom sacrifice everything for her children, working herself to the bone day-in and day-out, made Emily extra cautious about planning her family. The couple were barely able to afford the high-deductible health insurance plan offered by their employer, and the nearest hospital was a long distance from them. Despite the barriers, Emily did see a doctor and went on the pill after her wedding.

A few years passed. They were trying so hard to save for their future family, but it was difficult for Sam to work consistently. The dealer had to close down, and they were both working odd jobs just to get by. They were still excited for the day when they would welcome their first baby, but it seemed less hopeful as time passed. A few times, Emily had let her prescription lapse because she simply could not make time or get the transportation all the way her doctor's office. Twice, she opted for telehealth visits, but the charge for these was over $200 each, just for a medication check. She tried to find ways to get her prescription without having to pay the high cost of doctor visit each time. They simply could not afford this extra expense.

Sam became increasingly depressed about work challenges, and he struggled with alcohol. Then one day, they received an eviction notice. Sam and Emily were forced to move back into her mother's home and to live in the unfinished basement for the time being. Emily worried about Sam every minute of the day, as the trauma of her father's death boiled up to the surface again. And then, amidst all of this, she missed a period… and then another… and then… another.

She had been off of the pill for several months because she could not afford the doctor visit required to renew her prescription. She was desperate… as much as she dreamed of being a mother, now was not the time. Every night, she held her breath, waiting to see Sam walk through the door… secretly terrified he may take his own life at any moment. Feeling trapped, she made the sad decision to contact an online provider who could get her access to the abortion pill.

She went downstairs and locked the door behind her. In that dark and dank space, sitting on pile of dirty laundry, tears streaming down her face… she went to the website and completed the short questionnaire. Her body shaking with fear and sadness, she could barely click the link to connect with the consultant. To her surprise, the person who appeared on the screen was not even human, it was an animated avatar of what was supposed to look like a nurse or doctor. The image asked her some questions, she answered them, and they disconnected. For the bargain price of $99, her "way-out" pill was being overnighted directly to her address.

Emily… beautiful, smart, talented Emily… so full of potential and so excited to someday be a mom… Emily hid downstairs after everyone left for work and school the next day. She got down on knees next to the washing machine. She prayed. She cried, she screamed up to God, asking why He seemed to have abandoned her. Why was this happening? And then, she did what she thought she had to do.

The next few hours were the worst of her life. Emily plummeted into a downward spiral of despair, at times, even considering suicide. By late afternoon, she was filled with regret, and her body was in furor. She desperately searched online for a way to get out of this mess, and she found a hotline for a pregnancy resource center. She called… they counseled her, and she learned that reversing the abortion might be possible, if she could get to them quickly. Emily walked to her mother's workplace, got her car keys, and drove 3 hours to the clinic, where she was hoping and praying to save her baby's life.

Upon arrival, she was screened and brought into a small room for an ultrasound. What happened next is actually horrifying. On the screen, there was no image. There was no baby. No little life. No heartbeat. Emily was not, and had not been pregnant. The online avatar had not even asked if she had taken a pregnancy test. She fell to the floor, sobbing. In this moment, she knew God heard her. She knew that from then on, everything would be alright.

Though it was a struggle, Emily and Sam made it through the tough times. They now have three beautiful daughters. When I asked Emily if I could share her story, she not only agreed, she begged me to. Had she been able to renew her prescription with the local pharmacist, rather than traveling miles to a doctor or paying $200 for telehealth visits, her whole ordeal may have been avoidable.

Skyrocketing health care costs are forcing people into desperate situations. The law requires medication checks with prescribing doctors on a periodic basis, but these appointments can be extremely cost prohibitive, like they were for Emily. A lack of providers in parts of Wisconsin is a serious barrier to access to care, too. 30 states and the District of Columbia, as well as most European countries, allow pharmacists to prescribe oral contraceptives with some level of screening for medical history and associated risk factors.

Men can get medications for erectile dysfunction and hair loss with a few clicks on their smartphones, but women are often put through the wringer when it comes to access to low-risk, self-administered contraceptives. Increased access to safe contraceptives means higher rates of pregnancy prevention, resulting in less women seeking abortion services. It's time Wisconsin sees the need and practicality of adopting AB 43.

Sadly, as for Emily, it's sometimes easier to get access to abortion in Wisconsin than it is to get a prescription for the pill. As an advocate of the unborn and strong supporter of life, I would rather live in a world where pregnancy is prevented than where women use abortion as birth control. On behalf of Emily, and all women facing high healthcare cost barriers to contraceptives, I urge this committee to support this common sense legislation.

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TESTIMONY IN OPPOSITION OF ASSEMBLY BILL 43
ASSEMBLY COMMITTEE ON HEALTH, AGING, AND LONG-TERM CARE
WEDNESDAY, APRIL 23, 2025

Thank you, Chairman Moses and committee members, for the opportunity to submit testimony on Assembly Bill 43. Wisconsin Family Action opposes this bill. We acknowledge the stated intent of the authors, but we believe the problems that come with this proposal outweigh the good intentions.

First, to 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. Some contraceptives are known to cause a pre-implantation chemical abortion, which can happen when a contraceptive drug or device prevents a fertilized egg from implanting in the uterine wall. 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.

Allowing pharmacists to prescribe and dispense contraception, at least to some degree, will encourage unmarried individuals to engage in sexual activity. 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.

Second, to address the argument that passing this bill will help reduce poverty because it will reduce unwanted pregnancies, 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. If this body is interested in reducing poverty in meaningful ways, Wisconsin Family Action recommends 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 would have a far greater impact on poverty—especially generational poverty—than will allowing pharmacists to prescribe contraceptive devices and drugs.

Third, we also have concerns that this bill never uses the word woman, but rather uses "person" 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. 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. Nothing in the bill clearly prevents the above scenario from happening.

Further, we are concerned about the well-being of the individual woman seeking the contraception. Based on the very limited information required by the bill, ("a self-assessment questionnaire and a blood pressure screening"), 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 self-reporting his/her medical situation historically and currently. Inaccurate medical information could be dangerous, even in some instances fatal.

According to the Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use[3], there are clearly a significant number of medical conditions which 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.

It is important to note that 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. Dr. Patricia Giebink[4], an obstetrician-gynecologist in Chamberlain, South Dakota states, "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."

Finally, we 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. Senate Bill 42 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. With the addition of "any qualified pharmacy employee," this potential violation of religious or conscience rights seems to be expanded.

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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[3] https://www.cdc.gov/contraception/media/pdfs/2024/07/us-mec-summary-chart-color-508.pdf

[4] Dr. Giebink 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.

Wisconsin Nurses Association

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April 23, 2025

State Representative Clint Moses, Chair
Assembly Committee on Health, Aging and Long-Term Care
Room 12 West
State Capitol
Madison, WI 53708

RE: Wisconsin Nurses Association Support of AB 44 and the Senate Companion Bill, SB 43, allowing advanced practice nurse prescribers (APNP) to pronounce the date, time, and place of a patient's death

Dear Chairperson Moses and members of the Assembly Committee on Health, Aging and Long-Term Care,

My name is Gina Dennik-Champion, and I am an RN and Executive Director of the Wisconsin Nurses Association (WNA). WNA is the professional nursing association with membership open to any RN or Advanced Practice Nurse in Wisconsin. Thank you for allowing me the opportunity to testify today on WNAs support of AB 44 and the companion bill SB 43. WNA would like to thank Representative Summerfield for sponsoring AB 44 and the state representatives and senators who have signed on in support.

Assembly Bill 44 will allow advanced practice nurse prescribers (APNP) to pronounce the date, time, and place of a patient's death for the purposes of the preparation of death records. APNPs are highly trained healthcare professionals with extensive clinical experience. They are educated in physiology, patient assessment, and end-of-life care, making them well-equipped to determine death based on medical criteria. You will find APRNs providing palliative care, care in emergency settings, long-term care facilities, acute care and other settings where management of end-of-life situations are occurring. In addition, as the patient's health care provider, APRNs will often have developed relationships with patients and families. Allowing them to pronounce death ensures continuity of care, providing a compassionate and familiar presence at a difficult time. This in turn has the potential to minimize unnecessary stress for families, who would otherwise wait for a physician's availability who in these cases, does not have knowledge about the patient.

In at least 24 states, laws already allow APRNs to pronounce death, recognizing their competence in doing so. Expanding this authority to APRNs will add to the list of other health care providers,

Physician Assistants and RNs providing Hospice Care who are legally allowed to perform this important function in Wisconsin.

As healthcare delivery continues to adapt—especially in rural or underserved areas—many states are reexamining and updating their scope-of-practice laws in response to 1. Physician shortages, 2. APRNs having the ability to be a patients' health care provider and 3. Supporting the patients' family. The passage of AB 44 in Wisconsin will achieve the goals of care related to their patient's death.

Thank you, Representative Summerfield, for sponsoring AB 44, and you Chairperson Moses for allowing a hearing today, the members of the Assembly Committee on Health, Aging and Long-Term Care for listening to my testimony today. I ask on behalf of the WNA members, to pass AB 44 out of Committee as soon as possible.

I will gladly answer any questions you may have.

Sincerely,

Gina Dennik-Champion

Gina Dennik-Champion, MSN, RN, MSHA
WNA Executive Director

WISCONSIN CATHOLIC CONFERENCE

TO: Representative Clint Moses, Chair
Members, Assembly Committee on Health, Aging and Long-Term Care

FROM: Barbara Sella, Executive Director

DATE: April 23, 2025

RE: Opposition to AB 43, 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 Assembly Bill 43, 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. Pharmacists, while knowledgeable in medical management, are not equipped to provide the comprehensive medical expertise that physicians offer. Under AB 43, 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 has access to the woman's full medical history and can order diagnostic tests, but a pharmacist can only rely on the patient's self-assessment. Allowing pharmacists to prescribe these medications without a comprehensive medical history and examination compromises patient safety.

Hormonal contraceptives are potent 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] In May 2022, the FDA acknowledged the serious risk of breast cancer with hormonal contraceptive use, in particular by changing its safety prescribing protocols in partial response to a Citizens' Petition submitted by a group of concerned healthcare professionals and educators that formed the Contraceptive Study Group.[9] The Citizens' Petition presented research about the risks of hormonal contraceptives that revealed numerous harmful side effects. The petition requested that the FDA inform the public of those risks through reasonable labeling ("black box" warnings), but to date, most warnings have not been added.

Due to these harmful side effects, 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 why this proposal purposely sidesteps such care.

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While the bill includes a provision for pharmacists to have malpractice liability insurance, this does not mitigate the risk to patients. The potential for adverse outcomes remains. By circumventing normal standards of care, this bill helps pharmaceutical companies and pharmacies more than it helps women.

This bill will place legal pressure on pharmacists to prescribe contraceptives, even when the pharmacists may have medical or moral objections. Currently under Wisconsin Statutes s. 450.095, the duty to dispense contraceptives lies with a pharmacy, not the individual pharmacist. Current law thus 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 AB 43 become law, there will likely be great pressure through corporate policies to require pharmacists to prescribe and dispense.

Will the current protection for pharmacists to *not* prescribe contraceptives continue to exist? The bill says 'permit', but nowhere in the bill does it seem to leave room for judgment for the pharmacist not to prescribe and dispense, or refuse to give the self-assessment and blood pressure test in the first place.

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. Furthermore, now that there are extremely effective fertility-awareness-based methods, such as the Marquette Method developed here in Wisconsin, which give women the tools they need to understand and work with their own reproductive health, the State of Wisconsin should not be pushing for the expansion of powerful artificial drugs.[10] It is time for public policy to turn toward empowering women to understand their fertility, rather than masking it and pushing abortion if it fails.

Whether or not one agrees with the Church's stance on contraception, there are serious risks in this bill that should give everyone pause. Legislation that fails to promote and protect women's health and may coerce the medical judgment and conscience of individual pharmacists should not be supported. We respectfully urge you to oppose AB 43.

[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*.

[9] Contraceptive Study Group, *Petition on Hormonal Contraceptives* (May 2019), https://www.regulations.gov/document/FDA-2019-P-2289-0001. See also *National Cancer Institute (NCI) and University of Oxford Study Acknowledge Breast Cancer Risk of Hormonal Contraceptives (The Pill): Contraceptive Study Group (CSG) comments on incomplete response from FDA* (Apr. 2023), https://www.usccb.org/resources/2023 Letter to Head of FDA.docx.

[10] Qiyan Mu, Richard J. Fehring, and Thomas Bouchard. *Multisite Effectiveness Study of the Marquette Method of Natural Family Planning Program.* Linacre Quarterly, 89(1):64-72 (Feb. 2022), doi: 10.1177/0024363920957515.

To: Members, Assembly Committee on Health, Aging, and Long-Term Care

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

Date: March 12, 2025

Subject: Testimony in Support of Assembly Bill 43

Members of the Committee, thank you very much for allowing me to provide testimony in favor of Assembly Bill 43. 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 and undergraduate students. I educate students on all things related to 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 and how to monitor safety of the medication over time.

According to the CDC, 42% of all pregnancies are unintended.[1] Unintended pregnancies are associated with poor outcomes for both mother and infant including low birthweight, 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. 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.[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 is a hormonal contraceptive is a blood pressure assessment which pharmacists are trained to perform and evaluate. This bill also requires that pharmacists 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 specific 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 providers 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 use of the self-administered questionnaire is sufficient to identify whether an individual has risk factors that would preclude them from use of a hormonal contraceptive. The items included on the questionnaire are the same items that a physician would ask in a visit with a patient. Additionally, pharmacists can see exactly which medications the patient is filling at their pharmacy which would allow them to check for drug-drug interactions and ask clarifying questions about their medical history if needed. Additionally, pregnancy itself is associated with greater risk of thromboembolic events (i.e., clots) than hormonal contraception is.

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 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, including clinical decision making about contraception. In fact, just last week I provided an hour education session to 8 of our medical residents about initiating and monitoring hormonal contraception. 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. And we are proactively teaching them how to do so.

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 8am-5pm but can go to the pharmacy after work at 6pm. 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. Pharmacist-prescribed contraception adds to the toolbox of available contraceptive options because every individual has unique needs and deserves equitable access to options that are best for them to be in control of their reproductive health.

I ask that you support Assembly Bill 43 as pharmacist-prescribed contraception is key to increasing patient access resulting in potentially less unintentional pregnancies and elective abortions, improved patient outcomes, and reduced costs for federal and state governments. I strongly believe that 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 43. I welcome any questions that you may have.

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Heather Weininger, Executive Director, Wisconsin Right to Life

Assembly Committee on Health, Aging and Long-Term Care

AB 43 Relating to: permitting pharmacists to prescribe certain contraceptives

Wednesday, April 23, 2025

Thank you to the Senate Committee on Health for the hearing today on SB 42, Senate Bill 42 Relating to: permitting pharmacists to prescribe certain contraceptives.

Wisconsin Right to Life is taking an other position on this bill. This is an informational item only for the members of the committee.

Recently, there has been a nationwide effort to make abortifacients, or abortion inducing drugs, more readily available and accessible. Including providing them via mail, without a clinic visit, and sidestepping safety measure such as waiting periods and necessary discussions with heath care providers.

All of these measures are deeply damaging to women, their unborn children, and make abortion more dangerous and widespread. It is the position of Wisconsin Right to Life that the life of each unborn child is protected and women protected from unsafe access to abortion inducing drugs.

Our efforts need to put a safeguard in place that would ensure this bill does not allow for further expansion of drugs that pharmacists could prescribe, including dangerous abortifacients.

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To: Representative Clint Moses

Members, Assembly Committee on Health, Aging & Long-Term Care

From: Kassandra Bartelme, Pharm.D., BCACP

Professor of Pharmacy Practice

Ambulatory Care Pharmacist

Date: April 22, 2025

Subject: Testimony in Support of Assembly Bill 43

Representative Clint Moses and members of the Committee, thank you very much for allowing me to provide testimony in favor of Assembly Bill 43. My name is Kassandra Bartelme and I am a faculty member at a School of Pharmacy and ambulatory care pharmacist. I teach women's health pharmacotherapy topics to pharmacy students, including contraception (4 hours of instruction on contraception). I have also taught contraception to physician assistant students (2 hours of instruction on contraception).

Pregnancy prevention is a public health concern as 41.6% of all pregnancies nationwide are unintentional, according to the Centers for Disease Control or Prevention (CDC).[1] In Wisconsin in 2017, 31% (26,340) of all pregnancies were unintended.[2] Of these unintended pregnancies in Wisconsin, 58% resulted in births, 27% in abortions, and 14% in fetal loss (miscarriages).[2]

Unintended pregnancies can have significant negative impact on women, their families, and society, including social and economic difficulties. It is worth noting that women who are economically disadvantaged are affected by unintended pregnancies and its consequences at a significantly higher rate than other women.[3] A study completed in 2011 compared the number of pregnancies in a group of women in the U.S. with low socioeconomic status (defined as self-reported receipt of public assistance or having difficulty paying for basic needs) and those without low socioeconomic status. The low socioeconomic group had 515 unintended pregnancies during 14,001 women-years compared to 200 unintended pregnancies during 10,296 woman-years in participants without low socioeconomic status.[3]

Of the women in our country who have an unintended pregnancy, only 5% used a contraception method correctly.[4] Therefore, the vast majority of unintended pregnancies are in women who are not using contraception (52%) or use them inconsistently or incorrectly (43%). Women who have access to and use contraception are not the women getting pregnant unintentionally.

Additionally, in June 2022, the Supreme Court of the United States issued its decision in Dobbs v. Jackson Women's Health Organization and determined the U.S. Constitution does not provide the constitutional right to an abortion, overturning Roe v. Wade and Planned Parenthood v. Casey.[5] Wisconsin's statues 940.04 and 940.15 criminalize the intentional termination of a pregnancy unless it is necessary to save the life of the mother.[6,7] More recent statutes supersede these, but still mandate restrictions such as not allowing an abortion beyond 20 weeks postfertilization (Statute 253.107),[8] requiring a 24-hour waiting period, and requiring an ultrasound (Statute 253.10).[9] One way to prevent abortions of an unintended pregnancy is to provide easy access to contraception to prevent those unintended pregnancies.

AB 43 proposes that pharmacists be allowed to prescribe and dispense hormonal contraceptive patches and self-administered oral hormonal contraceptives to a person who is at least 18 years of age. Pharmacists are highly educated professionals that have the potential to increase access to contraception, therefore decreasing unintentional pregnancies and saving an untold amount of money in our healthcare system. Pharmacist-prescribed hormonal contraception is evidence-based and has been studied to show

feasibility and safety. For example, one study of 26 community pharmacists in Seattle who prescribed hormonal contraceptives to 195 patients found that 92.6% were still using the contraception at 1 month, 80.3% at 6 months, and 70% at 12 months.[10] Patients appreciated the convenience related to pharmacist accessibility. Additionally, 97.7% of patients were satisfied or very satisfied with their experience and reported it was convenient or very convenient to obtain hormonal contraception from a pharmacist compared to another provider. Upwards of 96.6% felt comfortable asking the pharmacist about their prescription or any other questions they have. This study shows patients were accepting and satisfied with obtaining a contraceptive prescription from a pharmacist.

The primary mechanism of action of the contraceptive pill and patch is to prevent ovulation.[9] These contraceptives are not abortifacients. They so reliably prevent ovulation that, when taken correctly, the likelihood of fertilization is quite low.[11] A secondary mechanism by which these medications prevent pregnancy is by altering the cervical mucus resulting in an inhospitable environment for sperm and preventing sperm penetration.[11] Therefore, even if ovulation occurred, it is unlikely sperm would be able to reach the egg to fertilize it. Additionally, the pill and patch may affect the endometrial lining, such as making it thinner. This may result in a lighter period for some women. There is insufficient evidence to demonstrate that this change could or would actually prevent implantation.[11]

A hormonal contraceptive pill and patch can be prescribed without a physical exam or other tests, with the exception of a blood pressure assessment, per the American College of Obstetricians and Gynecologists (ACOG) and the CDC's U.S. Selected Practice Recommendations for Contraceptive Use, 2024.[12,13] ACOG further states a blood pressure obtained in a non-clinical setting is acceptable. Any other tests or examinations, including a pelvic exam, do not contribute substantially to safe and effective use of these contraceptives. Additionally, ACOG and CDC state no routine follow-up is required after initiation of combined hormonal contraception.[12,13] Pharmacists are trained to perform blood pressure assessments. Pharmacists are also trained to educate patients on how and when to take medications and what to monitor for effectiveness and safety (e.g., side effects). Pharmacists are easily accessible during many, if not all, hours of the day for questions or problems related to their medications. As the prescriber, the pharmacist would be able to easily adjust a patient's contraception prescription if side effects occur, such as switching to a pill with a different hormone balance. Pharmacists are qualified to use patients' responses to a questionnaire to determine their eligibility for contraception using the CDC's Medical Eligibility Criteria for Contraceptive Use, 2024.[14]

My position at my university includes practicing as a pharmacist one and one-half days per week. I am an ambulatory care pharmacist and I work in a cardiology clinic alongside physicians, nurse practitioners, registered nurses, and other health care providers. I practice under a collaborative practice agreement that covers several diseases states, such as hypertension, hyperlipidemia, smoking cessation, asthma/COPD, and anticoagulation. My role in the cardiology clinic is to manage patients who take warfarin (Coumadin) which is a blood thinning medication taken to prevent clots and strokes. Our pharmacist-run anticoagulation clinics manage over 500 patients. Some patients make an appointment with me for an INR (International Normalized Ratio) which is a blood test that measures how thin their blood is. I perform the point-of-care finger stick test. Other patients go to a nearby clinic to get it done or via in-home services and we provide telephonic services to them. I adjust each patient's warfarin dose based on their INR result without consulting a physician. The goal is to keep a patient's INR between 2-3 or 2.5-3.5 depending on the reason for the medication. This means the patient's blood is thinner than someone who is not taking warfarin (whose INR would be 1 or 1.1). Warfarin is a high-alert medication per the Institute for Safe Medication Practices.[15] This means it bears a heightened risk of causing significant patient harm when they are used in error. Consequences of errors with high-alert medications are more devastating to patients. Warfarin has a high risk of causing bleeding if the INR gets too high and the risk of clots or strokes is higher in these patients if the INR is too low. The INR goal range is the sweet spot between those two risks and it can be challenging to keep the INR within that goal range. There are many food and drug interactions with warfarin that can cause changes in a patient's INR. The contraceptive pill

and patch are not listed as high-alert medications. If the physicians I work with are comfortable with me, a pharmacist, dosing warfarin and other high-alert medications such as insulin, there is no reason why a pharmacist couldn't manage and prescribe contraceptives. Pharmacists managing anticoagulation is quite common and a simple Google search will reveal there are many pharmacist-managed anticoagulation clinics nationwide.

Pharmacist-prescribed contraception may help fill a gap caused by a shortage of primary care physicians and OB-GYN physicians in Wisconsin. According to the Wisconsin Council on Medical Education and Workforce 2018 Healthcare Workforce Report, the majority (82.5%) of Wisconsin's total physicians are in metropolitan areas, yet only 71% of Wisconsin's population is located in those areas.[16] Less than 10% of physicians practice in rural areas, yet nearly 1/5th of the population lives in rural areas of the state. The primary care physician workforce is projected to increase by 3.8% but nearly 40% are expected to retire by 2035, causing a deficit of primary care physicians in the state.[16] The rural areas are likely to be hit the hardest. Many rural areas have a pharmacy at which pharmacists are more easily accessible than primary care physicians. In fact, about 90% of Americans live within five miles of a pharmacy.[17] This means patients who have trouble accessing a primary care physician or an OB-GYN due to location or time to get an appointment would be able to obtain contraception at their local pharmacy, increasing access and potentially decreasing the number of unintentional pregnancies. A study in Oregon showed their pharmacists prescribed contraception to a total of 367 Medicaid patients. Of those, 73.8% had no history of contraception prescriptions in the previous 30 days and 61.5% had no history in the previous 180 days, indicating that these patients were initiating hormonal contraceptive care in the pharmacy.[18] Patients who have not used contraception in the recent past or ever are seeking contraception from a pharmacist.

Unintended pregnancies are also costly to state and federal governments. In 2010, $21 billion was spent by state and federal governments nationwide. In Wisconsin, 62% of unplanned births were 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.[19] In 2010, publicly funded family planning services provided by safety-net health centers in Wisconsin helped save the federal and state governments $171.5 million.[19] A research study in Oregon demonstrated their policy allowing pharmacists to prescribe contraception averted an estimated 51 unintended pregnancies among their Medicaid population and saved $1.6 million dollars.[20] Imagine what pharmacists could do in Wisconsin!

Of note, a nonprescription progestin-only oral contraception, norgestrel (Opill) is now available. While this helps to increase access to contraception for those who are not able to see a medical provider for a prescription, this does not negate the need for pharmacist prescribing of the combined hormonal pill or patch. They offer different benefits. The nonprescription pill is a progestin-only pill which means it does not contain estrogen. This is great for patients who are not able to use estrogen due to other comorbid conditions. On the other hand, it does have a strict adherence requirement. If the progestin-only pill is taken more than three hours late, the effectiveness of the pill may be compromised, and patient has to use a back-up method such as a condom or abstain from sexual intercourse for 48 hours to prevent pregnancy. The combination oral pill and transdermal patch contains estrogen and progestin. The pill and the patch both have a 48-hour window before a patient needs to use back-up or abstain.[13]

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

Thank you again for the opportunity to provide testimony in favor of AB 43.

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