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R STREET POLICY STUDY NO. 159
November 2018

BIRTH CONTROL IN THE STATES: A REVIEW OF EFFORTS TO EXPAND ACCESS

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INTRODUCTION

Discussions about hormonal contraception often veer off into important but tangential issues such as abortion, sexual morality and healthcare funding. But there is a needed debate about this topic that can avoid almost all of the controversy. It centers simply on *access*—on practical ways to remove government regulatory barriers that make it difficult and unnecessarily costly for women to readily purchase birth-control products. Hormonal birth control dramatically reduces unintended pregnancy rates and expands a woman’s autonomy to choose her family planning methods. Not surprisingly, then, there should be plenty of common ground to pursue simple measures that make it more easily available. And, as in many policy areas, the states are already leading the way.

A FOCUS ON COMMERCIAL FREEDOM

To date, public-policy debates about birth control have been tied up in the kind of divisive social and moral issues that are

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at the heart of the nation’s “culture wars.” This is because, to be sure, the issue touches on one of the most private parts of our lives—sexual activity—and thus it can easily veer into discussions about the beginnings of human life. Birth control also pulls at a deeply entangled thread with respect to the nation’s complex healthcare system. While these debates usually dominate the airwaves, they miss an important part of the conversation: namely, that safe, time-tested birth control methods that many women use are subject to regulatory overreach. Birth control pills, for example, are used by more than 10 million American women. What is perfectly legal, however, is not necessarily easy to obtain thanks to barriers that the state and federal governments put in the way.

Libertarians and conservatives should care about this issue because it centers on “commercial freedom” and the right for adults to make their own choices about the legal products they want to use. Government should not be an impediment to such commerce or personal choices. Furthermore, those on the political right have expressed frustration at the way that federal bureaucracies—in this case, the Food and Drug Administration (FDA)—hamper public health, private industry and societal progress. In recent years, liberals have also routinely criticized the FDA bottleneck. The political left is known for its long-time concern about improving women’s ability to control their reproductive choices and about implementing cost-effective healthcare (mostly through government subsidization). For these reasons, removing government impediments to hormonal birth control products should be appealing to both groups because simple, practical reforms can advance everyone’s stated goals.

In fact, some of the most liberal and conservative states, from California to Utah, have managed to pass laws that expand access to birth control without enduring much divisive push-back. Likewise, at the federal level, conservative Republicans and liberal Democrats have both recognized the need to reform the FDA's drug-approval process. And thankfully, state lawmakers have shown that these types of approaches can be pursued effectively without stepping into a cultural miasma.

People who choose to be sexually active should be able to buy and use birth control and they should be able to do so without facing medically superfluous hurdles. To that end, federal and state governments must stop micromanaging the public's access to birth control through government-imposed barriers. Put simply, birth-control access is similar to other burdensome regulations in that bureaucratic red tape drives up costs and makes products less available, especially for people with lower incomes.¹ And, for this reason, these unnecessary barriers should be removed.

CURRENT IMPEDIMENTS

The current impediments to sound birth control policy fall into three categories: the limited availability of medical care in many rural communities; a lack of insurance coverage for many women seeking birth control; and the inconvenience for many women of making a medical appointment in order to gain access to a regularly used product.

Limited Availability

At first blush, getting a prescription to birth control products seems straightforward. A woman makes an appointment with her doctor, typically has some type of examination and then receives a prescription. She then heads to the local pharmacist, where she picks it up. But many women face hurdles even to obtain a prescription and then additional ones to fill it. To start, to get a prescription can be daunting for women who live in rural areas in particular, as they often need to travel great distances to see a physician. In fact, nearly 23 percent of women in rural America have only limited access to reproductive-specific healthcare. Women can receive birth control from general-practice doctors but there are severe shortages of such doctors in rural areas, also. According to the federal Health Resources and Services Administration, as of June 2018:

[T]here were more than 7,200 designated Health Professional Shortage Areas lacking adequate primary care nationwide – home to 85.5 million people. Of those areas, according to the HRSA, nearly 60 percent

1. Caroline Kitchens, "It's time for the feds to stop micromanaging birth control in the US," *The Hill*, Aug. 21, 2017. <https://thehill.com/blogs/pundits-blog/healthcare/347138-its-time-for-the-feds-to-stop-micromanaging-birth-control-in>.

were in rural regions, and the nation needed 4,022 rural doctors to close the gap.²

Lack of Insurance

Even in metropolitan areas, a sizable number of women have no health coverage, which makes a doctor's visit difficult and expensive. And, while it is true that since the passage of the Affordable Care Act, the numbers of uninsured women in childbearing years who lack any health coverage has declined significantly (and continues to decline), the Guttmacher Institute reports that as many as 8.2 million women between ages 15-44 still lack such coverage.³ What's more, the number for women in the country who are undocumented—and thus likely without health insurance—is estimated at triple the rate of those who are U.S. citizens.⁴ The bottom line: Gaining access to hormonal birth control can be difficult for millions of women living in the United States in rural and urban areas alike.

Inconvenience

For the overwhelming majority of women who are covered by healthcare plans, the current process of visiting a doctor and receiving a prescription can be cumbersome and serves as a disincentive for using the most effective forms of birth control (Figure 1).

As a result, the rate of unwanted pregnancies remains unnecessarily high. Barriers include the costs and the fact that a doctor's visit can be time-consuming and an embarrassment—especially for young adults. Visiting an OB-GYN often means taking time off work. It can also be difficult to find an available doctor in the first place and people without health insurance or with lower incomes are reluctant to make such appointments.⁵ Fortunately, states as liberal as California and as conservative as Utah are oftentimes in agreement on some of the obvious solutions.

EXPANDING ACCESS VIA THE PHARMACY-ACCESS MODEL

Generally speaking, there are four main ways to expand access to birth control using what is referred to as the "pharmacy-access" model: to allow pharmacists to prescribe, to

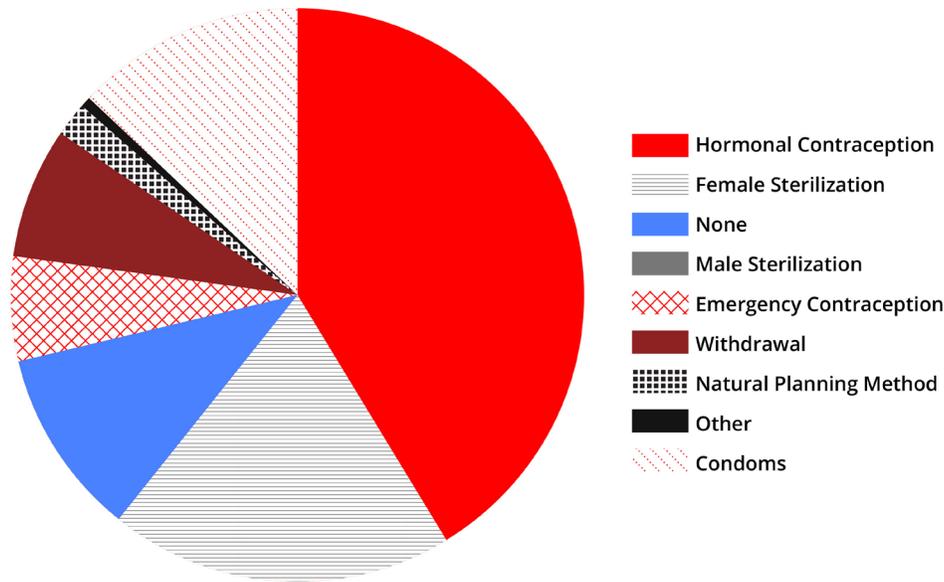
2. Joseph P. Williams, "Wanted: Rural Doctors," *US News and World Report*, Aug. 22, 2018. <https://www.usnews.com/news/healthiest-communities/articles/2018-08-22/rural-doctor-shortage-a-drag-on-community-health>.

3. Sneha Barot, "Moving Oral Contraceptives to Over-the-Counter Status: Policy Versus Politics," The Guttmacher Institute, Nov. 5, 2015. <https://www.guttmacher.org/gpr/2015/11/moving-oral-contraceptives-over-counter-status-policy-versus-politics>

4. Ibid.

5. Michael E. Martinez and Brian W. Ward, "Health Care Access and Utilization Among Adults Aged 18-64, by Poverty Level: United States 2013-2015," National Center for Health Statistics, October 2016. <https://www.cdc.gov/nchs/products/databriefs/db262.htm>.

FIGURE I: CONTRACEPTIVE USE AMONG REPRODUCTIVELY FERTILE AMERICAN WOMEN (AGES 15-44)



Source: Created by Authors. Graphics by Caroline M. Peni.

reform scope-of-practice laws, to expand access through the internet and to allow over-the-counter contraception. Each of these is discussed in more detail below.

Allowing Pharmacists to Prescribe

The simplest, short-term approach to expanding access to hormonal birth control is to allow pharmacists to prescribe products like pills, patches, injections and vaginal rings. This alleviates the need for visits to a licensed physician for these common methods but still provides some professional oversight in that a woman can visit her nearest pharmacy for an exam. There, the pharmacist conducts some basic health diagnostics—usually blood pressure and a medical questionnaire approved by the state—and then he or she provides the prescription on the spot.

As the trade publication *Pharmacy Times* explains:

It is generally universal that pharmacists must obtain a patient's relevant medical history, pregnancy status, and medication history, as well as perform blood pressure screening, before authorizing a prescription. This is achieved with a one-page self-screening questionnaire, similar to those used for immunizations.⁶

This process eliminates waits for a doctor's appointment, is generally available for a lower cost to the patient than a doc-

tor's visit and solves the problem of rural women who live far from a doctor. Further, the United States has already experienced slight growth in the number of community pharmacies, with now over 90 percent of Americans living within two miles of one.⁷

Reforming Scope-of-Practice Laws for Contraception

When dealing with government restrictions on commercial freedom, such as occupational-licensing laws that impose hundreds of hours of training requirements on people who want to work in a particular field, it is not hard to uncover the disingenuous reason such rules often exist. In fact, despite the fact that it is often the *stated* goal, it is rarely about protecting the public. On the contrary, frequently, these arbitrary requirements exist merely to restrict competition. Typically, established industries lobby the government to create licensing boards that oversee licensing standards. And, these boards are dominated by industry incumbents. For instance, optometrists have lobbied against new apps that would allow people to buy prescription glasses without seeing an optometrist.⁸

Usually, such entrenched interests are the main obstacle to reform but that is not the case when it comes to birth

6. Erin N. Deja and Joseph L. Fink III, "Pharmacists Prescribing Birth Control: Improving Access and Advancing the Profession," *Pharmacy Times*, Nov. 16, 2016. <https://www.pharmacytimes.com/publications/issue/2016/november2016/pharmacists-prescribing-birth-control-improving-access-and-advancing-the-profession>.

7. Dima Mazen Gato et al., "The availability of pharmacies in the United States: 2007-2015," *PLOS One*, Aug. 16, 2017. <https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0183172&type=printable>.

8. Meg Graham, "Optervative fighting states that try to ban its online eye exams," *Chicago Tribune*, April 5, 2016. <http://www.chicagotribune.com/bluesky/originals/optervative-legislation-online-exams-bsi-20160405-story.html>.

control. In fact, the organizations representing OB-GYNs do not oppose state laws that allow pharmacists to prescribe birth control. In an atypical example of commercial-regulation reform, OB-GYNs have actually been at the forefront of efforts to make birth control more readily available. This makes the case for expanding access even more compelling, given that one of the key types of opposition to such reforms does not exist in this case.

Perhaps this is because physicians—and OB-GYNs in particular—already have an overwhelming number of patients to handle and are often underrepresented in certain regions. In particular, the American Congress of Obstetricians and Gynecologists, the nation’s largest organization representing OB-GYNs, supports laws that allow women to access hormonal birth control without first being examined by a doctor:

Birth control is an essential part of women’s health care, and over-the-counter status would help more women benefit from the ability to control their own reproductive health [...] Of course, decades of use have proven that oral contraceptives are safe for the vast majority of women, and that they are safer than many other medications that are already available over-the-counter.⁹

The cost of a consultation with the pharmacist is typically around \$40 to \$50 and insurance providers cover it just as if it were provided following a doctor’s visit.¹⁰ Further, several states require that insurers provide a year’s worth of the prescription irrespective of who prescribes it (California, Colorado, Hawaii, Illinois, Maine, Nevada, New York, Oregon, Vermont, Virginia, Washington and Washington D.C.). Unfortunately, however, such mandates complicate these access discussions, often diverting attention away from the issue of access and toward merely who pays for it. This makes simple efforts to make birth-control products more readily available far more controversial. However, the lack of vocal opposition by OB-GYNs reinforces what should be the noncontroversial nature of a birth-control approach focused on expanding access.

Expanding Access through the Internet

As technology advances, so does the ability to obtain birth control prescriptions online. Companies like Lemonaid, Nurx and Maven operate like an “online doctor’s office,” giving patients the ability to fill out a medical questionnaire, get screen time with a doctor and then have a birth

control prescription delivered to them.¹¹ While this model is of growing importance, telemedicine laws vary by state, which means online consultations and prescriptions are not available everywhere. Certainly, as more states consider telemedicine reform, online companies will play a bigger role in birth-control access.

Allowing Over-the-Counter Access

Of all the available options, the ultimate goal is for the FDA to allow over-the-counter access to contraceptive products—just as it does for many other commonly and widely used, safe medications. And indeed, if this kind of access were allowed, women could go into a pharmacy and purchase hormonal contraception in the same way that they purchase tens of thousands of other medicines, ranging from cold tablets to pain medicine. In fact, a study this year published in the peer-reviewed journal *Women’s Health Issues* found overwhelming support for such a proposition. According to the study: “Thirty-nine percent of adults and 29 percent of teens reported likely use of an over-the-counter (progestin-only birth-control pill),” and further, it found that “if covered by insurance, likelihood of use increased to approximately 46 percent among adults and 40 percent among teens.”¹² Significantly, nearly 25 percent of women who are not now using contraception “said they would be interested in using an over-the-counter progestin-only pill.”¹³ The latter point conforms to other studies that suggest people are far less likely to use all types of medications if they can get them only by prescription. Of note, the progestin-only pill does not require a blood-pressure test since it is safe for women with high blood pressure, which further reduces the need for a medical examination.

The study also rebuts any concern about women foregoing broader gynecological care.¹⁴ Eighty-five percent of the women surveyed said they would continue to see their physician to receive routine gynecological screenings and pap smears. This reminds us that adults and even teens tend to be savvy about their own healthcare—even without the government forcing them to look after themselves by limiting their access to products that are beneficial to them.

With respect to actual health concerns, no pharmaceutical or medical intervention—including birth control—is completely safe. In fact, anything one buys in an over-the-counter or prescription manner has risks, which explains (along with

9. “ACOG Statement on Pharmacist Prescribing Laws,” American College of Obstetricians and Gynecologists, Jan. 4, 2016. <https://www.acog.org/About-ACOG/News-Room/Statements/2016/ACOG-Statement-on-Pharmacist-Prescribing-Laws>.

10. “Few California retailers offer pharmacist-prescribed birth control, despite law,” *Science Daily*, December 2016. <https://www.sciencedaily.com/releases/2017/12/171212184129.htm>.

11. “How Lemonaid Works,” Lemonaid, accessed Nov. 7, 2018. <https://www.lemonaid-health.com>.

12. Kate Grindlay and Daniel Grossman, “Interest in Over-the-Counter Access to a Progestin-Only Pill among Women in the United States,” *Women’s Health Issues*, March-April 2018. [https://www.whijournal.com/article/S1049-3867\(17\)30292-X/fulltext](https://www.whijournal.com/article/S1049-3867(17)30292-X/fulltext).

13. *Ibid.*

14. *Ibid.*

concerns about liability) why all medications—even aspirin—come with directions for use and warning labels. But, as previously noted, birth control is widely viewed by the medical community as safe enough for over-the-counter access.¹⁵ In fact, the American Congress of Obstetricians and Gynecologists notes that:

Research has shown that women are very adept at self-screening for any potential risks. And, although some women may be at elevated risk of thromboembolism associated with hormonal contraceptives, we know that pregnancy raises that risk to a larger degree, so the ability to prevent pregnancy actually protects these women.¹⁶

Moreover, a 2012 study by Ibis Reproductive Health found that only 31 percent of the 147 countries it examined require such a cumbersome regimen to obtain birth control.¹⁷ And, a 2017 Johns Hopkins study found that oral contraceptives “are safe and highly effective among adolescents,” and that “contraindications are rarer among adolescents compared to adult women.”¹⁸

But, *Tonic* writer Jesse Hicks explains, the slow embrace of this idea may be more about regulatory disincentives than anything else:

If the science is settled why does the pill still require a prescription? For decades, the answer has been less based in science than in the fact that no drug companies were willing to go through the laborious process of getting an (over-the-counter) contraceptive approved.¹⁹

In other words, the problem revolves around the federal bureaucracy and the impediments it imposes for drug approvals.

THE FEDERAL LOGJAM

Notwithstanding the many arguments in favor of disintermediation, the federal Food and Drug Administration, which must approve any products that would be sold over the counter, is a bottleneck to such progress at the federal level. And this is despite the fact that, according to Daniel Grossman, a clinical professor at UC San Francisco: “The pill is one of the best-studied medicines on the market today, and it’s certainly safe enough to be available without a prescription.”²⁰

Despite this, companies are fearful of going through the FDA process to get over-the-counter approval because of what Grossman describes as the “fear of political interference—and the costs and uncertainty it introduces.”²¹ As an example, he explains: “When Plan B emergency contraception was being considered for over-the-counter sale, politicians of both parties intervened in the process, slowing it down and imposing an unreasonable age restriction, one that was lifted only after a 10-year legal battle.”²²

Long and costly slowdowns such as this unsurprisingly hinder companies from seeking over-the-counter approval for contraception more broadly. And, while one company, RA Pharma in Paris, is working with international nonprofit Ibis Reproductive Health to start the process of gaining FDA approval for an over-the-counter oral contraceptive pill, even for drugs that have already been evaluated on a prescription basis, the process can take years.

Indeed, in a 2016 television interview with Dr. Oz, then-candidate Donald Trump himself weighed in on the problem this federal logjam creates: “When you have to get a prescription, that’s a pretty tough something to climb [...] I would say it should not be a prescription. It should not be done by prescription. You have women that just aren’t in a position to go get a prescription.”²³ Such comments reinforce the notion that over-the-counter access is simply the best option.

Similarly, some conservatives in Congress introduced federal legislation last year that:

requires the Food and Drug Administration to prioritize review of supplemental drug applications [applications to modify the approved use of a drug] for contraceptive drugs intended for routine use that would

15. See, e.g., Solmaz Shotorbani et al., “Agreement between women’s and providers’ assessment of hormonal contraceptive risk factors,” *Contraception Journal* 73:5 (May 2006), pp. 501-06. [https://www.contraceptionjournal.org/article/S0010-7824\(05\)00479-8/pdf?utm_source=health.charybd.com&utm_medium=link&utm_campaign=article](https://www.contraceptionjournal.org/article/S0010-7824(05)00479-8/pdf?utm_source=health.charybd.com&utm_medium=link&utm_campaign=article).

16. “ACOG Statement on Pharmacist Prescribing Laws.” <https://www.acog.org/About-ACOG/News-Room/Statements/2016/ACOG-Statement-on-Pharmacist-Prescribing-Laws>.

17. Kate Grindlay et al., “Prescription requirements and over-the-counter access to oral contraceptives: a global review,” *Contraception* 88:1 (July 2013), p. 1 (results). [https://www.contraceptionjournal.org/article/S0010-7824\(12\)01029-3/abstract](https://www.contraceptionjournal.org/article/S0010-7824(12)01029-3/abstract).

18. Krishna Upadhyaya et al., “Over-the-Counter Access to Oral Contraceptives for Adolescents,” *Journal of Adolescent Health* 60:6 (June 2017). <https://www.ncbi.nlm.nih.gov/pubmed/28314704>.

19. Jesse Hicks, “Why Isn’t OTC Birth Control Already a Thing?,” *Tonic*, March 22, 2017. https://tonic.vice.com/en_us/article/z4k5q3/why-isnt-otc-birth-control-already-a-thing.

20. Daniel Grossman, “Birth control pills should not be prescription only,” *Los Angeles Times*, June 19, 2015. <http://www.latimes.com/opinion/op-ed/la-oe-grossman-otc-birth-control-pills-20150619-story.html>.

21. *Ibid.*

22. *Ibid.*

23. David Shefinski, “Trump: Birth control shouldn’t require a prescription,” *The Washington Times*, Sept. 15, 2016. <https://www.washingtontimes.com/news/2016/sep/15/trump-birth-control-shouldnt-require-prescription>.

FIGURE 3: STATE PHARMACY-ACCESS MODELS

| STATE |  Age Restrictions |  Oral Pills & Patch Only |
|----------------------|--|---|
| California | - | - |
| Colorado | X | X |
| District of Columbia | - | - |
| Hawaii | - | - |
| Maryland | - | - |
| New Hampshire | - | - |
| New Mexico | - | - |
| Oregon | X | - |
| Tennessee | X | X |
| Utah | X | - |
| Washington | X | X |

Source: Created by authors. Graphics by Caroline M. Peni.

California—California was technically the first state to pass a pharmacy-access bill in 2013 but the law was held up due to regulatory procedures until 2016. California’s law allows pharmacists to prescribe “self-administered hormonal contraception” to patients regardless of age or if they have had a previous prescription.

Colorado—Colorado’s pharmacy-access reform was issued through a statewide protocol in 2017 and allows pharmacists to prescribe hormonal pills and patches to patients over 18 and for a duration of up to three years. Pharmacists must complete a training program and adhere to the United States Medical Eligibility Criteria when deciding whether a patient is a good fit for hormonal birth control.

Hawaii—Signed in 2017, Hawaii’s pharmacy-access law allows pharmacists to prescribe birth control to women—regardless of age—after completing training and having a written collaborative-practice agreement with a physician. It also states that reimbursement for contraceptive prescriptions and dispensation must extend to pharmacists providing those services.

Maryland—In early 2018, Maryland passed a bill allowing the Board of Pharmacy to write rules regarding pharmacists prescribing contraception.²⁶ In early 2019, Maryland pharmacists will be able to prescribe birth control to patients for up to 12 months, as long as the pharmacist has completed an approved training program and adheres to federal guidelines on eligibility criteria.

New Hampshire—In June 2016, New Hampshire passed a bill allowing pharmacists to prescribe contraception upon

26. Maryland pharmacists are not allowed to prescribe contraception until January 1, 2019.

obtaining a standing order with a physician. In addition to pills and patches, New Hampshire also allows prescriptions for vaginal rings. Patients can obtain a prescription regardless of age and pharmacists must complete an approved training program.

New Mexico—In 2017, New Mexico approved regulations allowing pharmacists to prescribe birth control. Pharmacists must also complete an approved training program and abide by state regulations as well as federal eligibility guidelines.

Oregon—Oregon was the first state to implement pharmacy access in 2015. It allows pharmacists to prescribe to patients over 18 and patients under 18, if they have had a prior prescription. Pharmacists must also undergo an approved training program and adhere to federal guidelines on eligibility. A pharmacist can prescribe for up to three years before a patient is required to see her regular doctor.

And, in addition to pills and patches, Oregon allows the DMPA injection (commonly known as Depo-Provera or Depo-Ralovera) to be administered by pharmacists who undergo additional training.²⁷

Tennessee—As of 2018, pharmacists in Tennessee can prescribe birth control pills and patches to women over 18 or women under 18, if they are emancipated minors. Pharmacists must also enter a collaborative agreement with a physician to be able to prescribe. As in every other pharmacy-access state, Tennessee pharmacists are subject to training requirements and adherence to federal guidelines.

Utah—Republican Gov. Gary Herbert signed Utah’s pharmacy-access law in March 2018. Specifically, Utah’s bill allows hormonal pills, the transdermal patch and the vaginal ring to be prescribed by a pharmacist to patients over 18, regardless of whether they have had a previous prescription. Pharmacists must obtain a standing order from a physician who is required to review such orders annually. Utah also requires a doctor’s visit within two years.²⁸ Pharmacists must undergo contraception-specific training and follow procedures and guidelines regulated by the state.

27. See, e.g., “S.B. 184 Pharmacist Dispensing Authority Amendments,” State of Utah (2018). <https://le.utah.gov/-2018/bills/static/SB0184.html>; “House Bill 1822-FN,” State of New Hampshire (2018). http://gencourt.state.nh.us/bill_status/billText.aspx?sv=2018&id=2046&txtFormat=pdf&v=current

Board of Pharmacy, “Contraceptives – Purpose,” Oregon Secretary of State, Ch. 855, Div. 19, 855-019-0400. <https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=19>.

28. Department of Regulatory Agencies, “Colorado State Board of Pharmacy Approved Statewide Protocol for Prescribing Hormonal Contraceptive Patches and Oral Contraceptives,” State of Colorado, effective March 2017. <http://www.ucdenver.edu/academics/colleges/pharmacy/AcademicPrograms/ContinuingEducation/COS-tatewideProtocols/COStatewideProtocolsHormonalContraception/Documents/Hormonal%20Contraception%20ProtocolA%20Full%20FINAL.pdf>; “S.B. 184 Pharmacist Dispensing Authority Amendments.” <https://le.utah.gov/-2018/bills/static/SB0184.html>.

That Utah's bill was sponsored by a Republican state senator and passed out of the GOP-dominated legislature unanimously, and considering the lack of opposition from the conservative Church of Jesus Christ of Latter-day Saints should be positive encouragement for other states considering similar measures.²⁹

Washington, D.C.—As of 2018, pharmacists in the District can prescribe birth control to women for up to 12 months at a time. The bill also specifies that insurance must cover birth control prescribed by a pharmacist. Patients must complete a risk assessment, as is required in every other pharmacy-access state and pharmacists must undergo training.

Washington—In 2016, Washington state passed a pharmacy-access bill allowing patients over 18 to receive birth control prescriptions from pharmacists who have completed training. Pharmacists can prescribe for up to three years before a woman must see her regular doctor.

ADDRESSING OUTSTANDING CONCERNS

Despite the promise that these ways to expand access have shown, several obstacles remain that currently impede their broader adoption but many of these are easily addressed by simply following the lead already available in the states.

Pharmacist Concerns

Perhaps the most unexpected obstacle to wider adoption of pharmacy-access models are the objections that come from pharmacists themselves and which lead to low participation—even in states that already allow it. For example, a 2017 study published in the *Journal of the American Medical Association* found that after a year of being in effect, only 11 percent of California pharmacies offered pharmacy-access service.³⁰ The study also identified several reasons why this is the case, and these must be considered and addressed if other states are to adopt these measures more broadly.

First, pharmacists have expressed concern about having to construct new infrastructure.³¹ This is understandable, as expansions such as these require capital, both in terms of training and facility expansion or renovation.³² Indeed, with respect to training in particular, a 2018 study found that: “Pharmacists have an initial lack of knowledge and perceived

lack of comfort with prescribing hormonal contraception if allowed in their state of practice.”³³ In fact, more than 70 percent of pharmacists surveyed pointed to a need for more training, while nearly 32 percent of them expressed liability concerns.³⁴ And while these hesitations certainly need to be addressed, the simple development of training programs and adoption of liability insurance coverage would easily assuage any fears.³⁵ And, this is especially true considering that training programs are already a requirement for most states that allow pharmacy access and thus there are already functioning models to emulate.

Another objection pharmacists expressed had to do with costs and payment, and in particular, with pharmacist reimbursement—wherein pharmacists who provide birth control prescriptions are reimbursed by the state or insurance for their services.³⁶ The ambiguity of how this would work continues to be a deterrent for some. And, while costs are an important consideration, more data is needed to establish price trends. For example, Hawaii explicitly requires contraception coverage under the Affordable Care Act to include prescriptions from pharmacists.³⁷

They are also concerned that the public is unaware that these services are offered, and thus the demand for the service might not be sufficient to justify the new infrastructure, staff and training expenditures required. Pharmacists also express concern that the new cost for the appointments will discourage people from taking advantage of the service.

Moreover, passing a pharmacy-access law does not entitle pharmacists to immediately start prescribing. For example, Tennessee's law took two years to implement, largely due to a lengthy rulemaking period, as state regulators struggled with concerns about potential side effects.³⁸ Because of a lack of precedent, the bureaucratic process took an unnecessarily long time. And this is a major consideration for states looking to adopt pharmacy access in the future. Indeed, eleven other states considered similar bills in 2018, but progress has

29. Michelle L. Price, “Conservative Utah Lets Women Get Birth Control From Pharmacy,” *Associated Press*, March 21, 2018. <https://www.usnews.com/news/best-states/utah/articles/2018-03-21/utah-oks-law-to-let-women-get-over-the-counter-birth-control>.

30. “Few California retailers offer pharmacist-prescribed birth control, despite law,” *Science Daily*, December 2017. <https://www.sciencedaily.com/releases/2017/12/171212184129.htm>.

31. *Ibid.*

32. *Ibid.*

33. I. Lio et al., “Pharmacists’ comfort level and knowledge about prescribing hormonal contraception in a supermarket chain pharmacy,” *Journal of the American Pharmacist’s Association* 58:4 (July-August 2018), p. 1. <https://www.ncbi.nlm.nih.gov/pubmed/30006191>.

34. *Ibid.*

35. *Ibid.*

36. “Few California retailers offer pharmacist-prescribed birth control, despite law.”

37. “S.B. No. 513,” Twenty-Ninth Legislature, State of Hawaii. https://www.capitol.hawaii.gov/session2017/bills/SB513_CD1_HTML.

38. Chas Sisk, “After Long Wait, Birth Control Is About To Be Available In Tennessee Without A Doctor’s Prescription,” *Nashville Public Radio*, June 28, 2018. <http://www.nashvillepublicradio.org/post/after-long-wait-birth-control-about-be-available-tennessee-without-doctor-s-prescription#stream/0>.

been slow, even in liberal states like Illinois, which thus far has failed to pass such a law.³⁹

Payment Concerns

There also are concerns about health insurance and payment that come from insurance companies and even women’s reproductive rights advocates. Some of the latter, for instance, have opposed some efforts to provide easier access to hormonal birth control out of fear that the products will not be covered by insurance. However, debates over insurance coverage for contraceptives can be untethered from the basic access and cost issues that are the focus of this paper.

Wider availability will result in competitive pressures that dramatically reduce prices. As the Cato Institute’s Jeffrey Singer explains:

When the FDA reclassifies a prescription drug to over-the-counter, it extracts it from the third-party spending trap [...] As consumers play their part, market forces often bring prices down and new competitors often enter the market. Contact lenses, while requiring a prescription, are not usually covered by insurance plans. Over the years, competition for consumers has driven down the prices of contact lenses as choices and options have increased. There is no reason to believe this won’t happen if all types of hormonal birth control are subjected to the same competitive forces.⁴⁰

Fears about costs are exacerbated by the current political climate, as well. The Trump administration has loosened rules in the Affordable Care Act (ACA) that require insurers to pay for oral contraceptives. Specifically, the administration has rolled back the Obama administration’s requirement that insurers cover contraceptive prescriptions without a copay. This concern highlights the fact that insurers do not usually cover over-the-counter drugs.

Unfortunately, however, this is merely another example of reforms meant to increase *access* being conflated with concerns over *payment*. These are separate issues and while the importance of payment concerns should not be downplayed, broader access is easier to achieve—and will almost certainly reduce costs—if it is unencumbered by more controversial issues.

39. “Illinois Issues: Birth Control Without the Doctor,” *Illinois Public Radio*, Aug. 14, 2018. <https://will.illinois.edu/news/story/illinois-issues-birth-control-without-the-doctor>.

40. Jeffrey A. Singer, “Free Birth Control from the Third Party Trap,” Cato Institute, Sept. 1, 2017. <https://www.cato.org/publications/commentary/free-birth-control-third-party-trap>.

Cultural Concerns

There has been little organized or vocal pushback in the states regarding moral concerns, however, lawmakers have experienced some generalized opposition at times. For instance, when Illinois considered a law allowing pharmacists to prescribe birth control, lawmakers expressed concerns about “morality and birth control use.”⁴¹ This is merely a roundabout way of getting at the real concern that some people have: namely, that easy access to birth control will increase risky sexual behavior among teenagers. But this is an unsubstantiated fear. The 2017 Johns Hopkins study noted that: “Ready access to (oral contraceptives), condoms, and emergency contraception increases their use without increasing sexual risk behaviors.”⁴² Indeed, it definitively concluded: “Our review strongly suggests that giving teens easier access to various contraceptives will not lead to more sex but would result in fewer unwanted pregnancies.”⁴³ This is likely also because it is easier for people to take a daily pill than it is for them to rely on less-effective, situational methods, such as condoms.⁴⁴

Put simply, by separating access issues from other issues involving logistics, payment and morality, we can help accomplish a simple goal that should be popular across the political aisle: Removing unnecessary government barriers so that women can more easily and affordably buy the hormonal contraception they want to use. Doing so promotes consumer choice and improves women’s reproductive health.

CONCLUSION

There is little debate and controversy about the value that hormonal birth control provides in preventing unwanted pregnancies and helping women plan their families. Expanding access to these products, via over-the-counter, pharmacist-prescribing and Internet sales, will likely lower prices, as has happened in other situations when products become more widely available and subject to competitive pressure. Until the federal government streamlines its drug-approval process, the states remain the best places to resolve this issue. Progress has been slow but there are encouraging signs that a bipartisan group of Americans can expand access to hormonal birth control—provided that they focus on access issues and leave the controversies for other forums.

41. *Ibid.*

42. Upadhyia et al., p. 1. <https://www.ncbi.nlm.nih.gov/pubmed/28314704>.

43. Johns Hopkins Medicine, “Experts Find Strong Case for Over-The-Counter Oral Contraceptives for Adults and Teens,” Press Release, March 14, 2017. https://www.hopkinsmedicine.org/news/media/releases/experts_find_strong_case_for_over_the_counter_oral_contraceptives_for_adults_and_teens.

44. “Effectiveness of Family Planning Methods,” Centers for Disease Control and Prevention, Feb. 9, 2017. <https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/pdf/Family-Planning-Methods-2014.pdf>.

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