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Prescription Restriction: Why Birth Control Must Be Over-the-Counter in the United States

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PRESCRIPTION RESTRICTION: WHY BIRTH
CONTROL MUST BE OVER-THE-COUNTER IN
THE UNITED STATES

*Susannah Iles**

ABSTRACT

This Note argues that it is harmful and unnecessary to require women to obtain prescriptions for access to hormonal birth control. Requiring a prescription is necessarily a barrier to access which hurts women and hamstring the ability to dictate their own reproductive plans. It is also an irrational regulation in light of the relative safety of hormonal birth control pills, particularly progestin-only formulations, compared to other drugs readily available on the shelves.

Leading medical organizations, including the American College of Obstetrics and Gynecologists, advocate for over-the-counter access to hormonal birth control. While acknowledging that not every woman will have positive outcomes taking hormonal birth control pills, this Note argues that women are capable of taking hormonal birth control as directed and are able to self-identify if they themselves are at risk for complications.

Following a long line of cases that establish reproduction as a fundamental right in the United States, it follows that requiring a prescription for access can and should be analyzed under the Fifth and Fourteenth Amendment Due Process clauses, particularly under the Undue Burden standard. Certain prerequisites, such as pelvic exams, once thought to be necessary to safely prescribe hormonal birth control, are now widely considered unnecessary in determining whether a particular woman can safely take birth control pills. This Note goes further and argues that such prerequisites are an unconstitutional method of holding vital medication hostage from women who desire to control their reproductive health.

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INTRODUCTION

In the United States, many women are travelling across the border for their birth control.¹ Women with low incomes, notably undocumented immigrants, often have to go underground for oral contraceptives. These women can cross the border into Mexico and buy Mexican-made birth control from local Yerberias (herbal medicinal shops) without prescriptions or purchase them from those who bring them back into the United States for the purpose of resale.² In Mexico, as in many countries, hormonal birth control pills are available without a prescription and without consulting a doctor.³

Women who have decreased access to physicians in the United States have great difficulty obtaining a prescription for their contraceptive needs but nevertheless rely on oral contraceptives because they are relatively cheap.⁴ A one-month dose of the pills costs around \$16 to \$20 on the black market, while an intrauterine device (IUD) inserted by a licensed professional can cost up to \$400 for insertion and \$400 for removal.⁵ For women of many identities, oral birth control represents an affordable, non-invasive, and effective means of family planning. Additionally, oral birth control is prescribed and used in the United States for a variety of secondary concerns: irregular menstrual periods, menstrual cramps, acne, and polycystic ovary syndrome, to name just a few.⁶

Despite the obvious demand for and necessity of oral contraceptives, the United States Food and Drug Administration (FDA) has never approved the over-the-counter sale of a daily hormonal oral contraceptive.⁷ To approve a drug for over-the-counter retail access, the FDA

1. *Uninsured Immigrant Women Go Underground for Birth Control Pills*, FREE SPEECH TV (Mar. 23, 2012), <https://freespeech.org/stories/uninsured-immigrant-women-go-underground-for-birth-control-pills/>.

2. *Id.*

3. *Id.*

4. *See id.* (“Some U.S.-born women . . . chose to cross the border into Mexico in order to have access to cheaper birth control than they would otherwise find in the U.S., much the same way that other prescription medicines are purchased at discount abroad.”).

5. *Id.*

6. *See Birth Control Pills: A Guide for Parents*, CENTER FOR YOUNG WOMEN’S HEALTH (Apr. 4, 2019), <https://youngwomenshealth.org/parents/birth-control-pills-parent/>.

7. *Cf.* BIRTH CONTROL, U.S. FOOD & DRUG ADMIN., June 3, 2018, <https://www.fda.gov/consumers/free-publications-women/birth-control>.

must find that it is not habit forming and that it can be used safely without supervision by a healthcare professional.⁸ Numerous medical professional organizations have expressed support for over-the-counter access to oral contraceptives, including the American Academy of Family Physicians, the American College of Obstetrics and Gynecologists, the American Medical Association, the American Public Health Association, and the Association of Reproductive Health Professionals.⁹

In order to maintain reproductive autonomy, women must have access to reliable contraceptives that are within their own control. Plan B, the brand name for a progestin-only emergency contraceptive, has been offered over-the-counter since 2006 to women 17 and older and to women and girls of all ages since 2009.¹⁰ Because monthly oral contraceptives come in progestin-only form, like Plan B, the FDA's failure to approve a non-emergency form of the contraceptive drug seems to be motivated by something other than concerns for women's health or the ability to use the drugs safely.

Instead, this Note argues the lack of over-the-counter access is a direct result of public policy concerns regarding female sexuality and autonomy that existed long before the emergence of oral contraceptives and continue to exist to this day. These policies cannot be justified in an era where women have the legal and social right to higher education, careers, and bodily autonomy and where such policies disproportionately affect women of color and low-income women.¹¹ Section I of this Note

8. See Kate Grindlay, et al., *Prescription Requirements and Over-the-Counter Access to Oral Contraceptives: A Global Review*, 88 *CONTRACEPTION* 91, 91–92 (2013).

9. See Daniel Grossman, *Over-the-Counter Access to Oral Contraceptives*, 42 *OBSTETRIC GYNECOLOGY CLINICS N. AM.* 619, 626 tbl. 1 (2015).

10. See *Tummino v. Hamburg*, 936 F. Supp. 2d 162, 164–65 (E.D.N.Y. 2013); *Tummino v. Torti*, 603 F. Supp. 2d 519, 550 (E.D.N.Y. 2009).

11. See Marcela Howard & Amy Starrs, *For Women of Color, Access to Vital Health Services is Threatened*, GUTTMACHER INST.: THE HILL'S CONG. BLOG (July 27, 2017), <https://www.guttmacher.org/article/2017/07/women-color-access-vital-health-services-threatened>. (“Women of color have long experienced stark health disparities in areas like cervical and breast cancer, unintended pregnancy, and pregnancy-related complications. The root causes stem from a long history of racism and discrimination, including lack of access to high-quality, affordable health insurance and care and, for some, a lingering mistrust of the medical community.”); *Disparities in Healthcare Quality Among Racial and Ethnic Groups*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, <https://archive.ahrq.gov/research/findings/nhqrd/r/nhqrd/r11/minority.pdf> (explaining disparities in access and quality of care for low-income individuals); *Unintended Pregnancy in the United States*, GUTTMACHER INST.: THE HILL'S CONG. BLOG, <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states> (describing higher rates of unintended pregnancy among women two-hundred percent below the federal poverty level).

examines the myths and misconceptions surrounding the use of oral contraceptives. Section II explains the FDA's over-the-counter regulatory scheme and why progestin-only oral contraceptives fit squarely within that scheme. In Section III, the discussion turns to policy concerns that help explain the lack of over-the-counter access, since health concerns arguably fail to do so. Section IV of this Note argues that the current over-the-counter availability both drugs that are more statistically dangerous and progestin-only emergency contraceptives belie the given justifications for continued withholding of oral contraceptives. Section IV then explores the equal protection and substantive due process implications of this issue.

I. MYTHS AND MISCONCEPTIONS

A. Myth: Non-Physicians Cannot Self-Diagnose for Contraindications to Progestin-Only Oral Contraceptives

Most contraindications, or reasons to avoid taking a drug or undergo a medical treatment, to oral contraceptive use can be determined using women's health history alone.¹² One of the most prominent misconceptions surrounding oral contraceptives is that physician-conducted tests, like a pap smear test, are necessary to obtain a prescription.¹³ Progestin-only oral contraceptives do come with some warnings, but they have a lower risk of cardiovascular disease and deep vein thrombosis than combined hormonal pills and other drugs that are already available over-the-counter.¹⁴ A World Health Organization study found no significant increase in the risk of stroke, myocardial infarction, and venous thromboembolism (a few of the most serious potential side effects arising from oral contraceptive use) among users of progestin-only contraceptives compared to women who did not use oral contraceptives.¹⁵ The

12. See Howard & Starrs, *supra* note 11.

13. See FREQUENTLY ASKED QUESTIONS, PLANNED PARENTHOOD SW. OR., <https://www.plannedparenthood.org/planned-parenthood-southwestern-oregon/patient-resources/frequently-asked-questions> (last visited Oct. 10, 2019).

14. See *Progestin-Only Hormonal Birth Control: Pill and Injection*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, <https://www.acog.org/Patients/FAQs/Progestin-Only-Hormonal-Birth-Control-Pill-and-Injection?IsMobileSet=false>; *infra* Section II: Journey to the Shelf at 16.

15. See David A. Grimes et al., *Progestin-only Pills for Contraception*, 11 COCHRANE DATABASE OF SYSTEMIC REVIEWS 1, 2 (2013) (For example, acetaminophen and certain antihistamines are considered to be more dangerous than progestin-only birth control).

most common side effects are related to irregular menstruation such as spotting, short or long cycles, or no bleeding at all.¹⁶ Women can detect these menstruation related side effects and discontinue use if necessary.

When a woman goes to a physician seeking a prescription for an oral contraceptive, the doctor determines whether she has a contraindication primarily by using her health history.¹⁷ With the exception of taking blood pressure, this checklist method can be performed accurately by female patients themselves.¹⁸ Further, many medical professionals believe prescribing oral contraceptives requires only minimal screening.¹⁹ The American College of Obstetrics and Gynecologists endorses the idea that women should self-screen for most medical contraindications to oral contraceptives.²⁰

Notably, Plan B is already available over-the-counter without age restrictions.²¹ As a progestin-only emergency contraceptive, it contains a one time, high dose of levonorgestrel, a type of progestin that is also used in many daily oral contraceptives.²² Potential side effects include an irregular period (early or late, heavier or lighter), nausea, cramping, fatigue, headache, dizziness, breast tenderness, and vomiting.²³ An overdose of Plan B is unlikely to be dangerous.²⁴ Restricting daily oral contraceptives to prescription-only is potentially arbitrary given Plan B's over-the-counter availability—Plan B is a progestin-only medication that works to prevent pregnancy by delaying ovulation.²⁵ The active ingredient is the same ingredient found in many hormonal birth control pills.²⁶

Furthermore, the perception of oral contraceptives as dangerous to women seems especially misplaced because more dangerous drugs are

16. *See id.* at 2–4.

17. *See* Grossman, *supra* note 9, at 621–22.

18. *See id.* at 625.

19. *See* Hanna Xu et al., *Medical Contraindications in Women Seeking Combined Hormonal Contraception*, 210-3 AM. J. OBSTETRICS & GYNECOLOGY, 210.e2 (2014).

20. Daniel Grossman et. al., *Accuracy of Self-Screening for Contraindications to Combined Oral Contraceptive Use*, AM. J. OF OBSTETRICS & GYNECOLOGY (Sept. 2008), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2615461/> (concluding that women who self-screened for contraindications to oral contraceptives using a medical checklist were relatively accurate).

21. *See* Tummino v. Hamburg, 936 F. Supp. 2d 162, 197–98 (E.D.N.Y. 2013).

22. *See* FREQUENTLY ASKED QUESTIONS, PLAN B ONE-STEP, <https://www.planbonestep.com/faqs/> (last visited Nov. 20, 2017).

23. *See id.*

24. *Plan B*, RX LIST, Aug. 6, 2019, <https://www.rxlist.com/plan-b-drug.htm#description>.

25. *See id.*

26. *Id.*

already available over-the-counter. Tylenol, for example, can cause liver failure and death when over-ingested.²⁷ The table below gives an overview of four drugs readily found in any drugstore, along with their commonly recognized brand names, potential side effects, and potential effects of overdoses.

Drug	Brand Name(s)	Potential Side Effects	Potential Effects of Overdose
Acetaminophen ²⁸	Actamin, Anacin AF, Apra, Bromo Seltzer, Children's Tylenol, Elixsure Fever/Pain, Mapap, Medi-Tabs, Q-Pap, Silapap Childrens, Tactinal, Tempra Quicklets, Tycolene, Tylenol, Vitapap; Also included in many over-the-counter combination medications such as Actifed, Alka-Seltzer Plus Liquid Gels, Cepacol, Contac, Coridicin, Dayquil, Dimetapp, Dristan, Excedrin, Feverall, Liquiprin, Midol, Nyquil, Panadol, Robitussin Singlet, Sinutab, Sudafed, Theraflu, Triaminic, Vanquish, Vicks, and Zicam ²⁹	Bloody stool, bloody urine, fever, skin rash, unusual tiredness or weakness, yellow eyes or skin ³⁰	Liver failure and death ³¹
Ibuprofen	Advil, Midol, Motrin, Motrin IB, Motrin Migraine Pain, Proprinal, Smart Sense Children's Ibuprofen, PediaCare Children's Pain Reliever/Fever Reducer, PediaCare Infant's Pain Reliever/Fever Reducer ³²	Upset stomach, heartburn, diarrhea, constipation, dizziness, headache, nervousness, blurred vision, ringing in ears, chest pain, shortness of breath, slurred speech,	Stomach bleeding, difficulty breathing, and coma ³⁴

27. Anna North, *Five Common Drugs More Dangerous Than Plan B*, JEZEBEL (Dec. 8, 2011), <http://jezebel.com/5866041/five-drugs-more-dangerous-than-plan-b>.

28. "Acetaminophen overdose is the leading cause for calls to poison control centers in the United States, accounting for more than 56,000 emergency room visits, 2,600 hospitalizations, and an estimated 458 deaths each year." William M. Lee, *Acetaminophen and the U.S. Acute Liver Failure Study Group: Lowering the Risks of Hepatic Failure*, HEPATOLOGY, July 2004, at 6. One reason acetaminophen is so dangerous is that it has a narrow safety margin, meaning the difference between a safe dose and an overdose is relatively small. Brian Palmer, *What's the Most Dangerous Over-the-Counter-Drug?*, SLATE (Dec. 8, 2011), http://www.slate.com/articles/health_and_science/explainer/2011/..._over_the_counter_are_they_more_dangerous_than_other_drugs.html.

29. *Acetaminophen*, DRUGS.COM (last updated Dec. 29, 2018), <https://www.drugs.com/acetaminophen.html>.

30. *Id.*

31. North, *supra* note 27.

32. *Ibuprofen*, DRUGS.COM (last updated Dec. 22, 2018), <https://www.drugs.com/ibuprofen.html>.

		balance issues, black or bloody stool, coughing up blood or vomit, swelling or rapid weight gain, stomach pain, jaundice, fever, blistering or peeling rash, bruising, severe tingling or numbness, neck stiffness, and seizure ³³	
Diphenhydramine	Allergy Relief, Allermax, Banophen, Benadryl, Compoz Nighttime Sleep Aid, Diphedryl, Diphenhist, Dytuss, Nytol QuickCaps, PediaCare Children's Allergy, Q-Dryl, QlearQuil Nighttime Allergy Relief, Quenalin, Scot-Tussin Allergy Relief Formula, Siladryl Allergy, Silphen Cough, Simply Sleep, Sleepinal, Sominex, Tranquil, Twilite, Unisom Sleepgels Maximum Strength, Valu-Dryl, Vanamine PD, Z-Sleep, ZzzQui ¹⁵⁵	Impaired ability to drive, fatigue, dizziness, headache, dry mouth, and difficulty urinating ³⁶	Fever, hallucinations, and seizures ³⁷
Dextromethorphan ³⁸	Babee Cof, Benylin DM Pediatric, Buckleys Mixture, Creomulsion, Creo-Terpin, DayQuil Cough, Delsym, Delsym 12 Hour Cough Relief, Elixsure Cough, Robafen Cough Liquidgels, Robitussin CoughGels, Scot-Tussin Diabetic, Silphen DM, St. Joseph Cough Suppressant, Sucrets DM Cough, Theraflu Thin Strips Cough, Triaminic Long Acting Cough ³⁹	Impaired thinking and delayed reactions, dizziness, headache, rash, nausea, vomiting, and upset stomach ⁴⁰	Irregular heartbeat, high blood pressure, brain lesions, epilepsy, and permanent psychosis ⁴¹

34. *Id.*

33. North, *supra* note 27.

35. *Diphenhydramine*, DRUGS.COM (last updated Dec. 19, 2018), <https://www.drugs.com/diphenhydramine.html>.

36. *Id.*

37. North, *supra* note 27.

38. Dextromethorphan is known to be taken recreationally in large quantities because it can induce hallucinations and euphoria. Matt McMillen, *FDA Panel Rejects Restrictions on Cough Medicine*, WEBMD (Sept. 14, 2010), <https://www.webmd.com/cold-and-flu/news/20100914/fda-panel-rejects-restrictions-on-cough-medicine>. The brand name Robitussin has caused at least one death. North, *supra* note 27.

39. *Dextromethorphan*, DRUGS.COM (last updated Mar. 4, 2019), <https://www.drugs.com/dextromethorphan.html>.

40. North, *supra* note 27.

41. *Id.*

This Note does not argue that the FDA should limit the availability of these ubiquitous over-the-counter drugs or that progestin-only emergency contraceptives should be removed from the shelves. Rather, the point of this brief overview is to illustrate the ease with which consumers are able to acquire potentially harmful drugs; the FDA has decided to trust the public to take them as directed and to recognize their own individual contraindications, so hormonal birth control should be no different.⁴²

B. Myth: Access to Oral Contraceptives Will Increase Sexual Risk-Taking

Perhaps the reason oral birth control is treated differently is because oral birth control, unlike pain-killers or allergy medication, enables women, especially young girls, to engage in more sexual risk-taking that endangers their health. While this explanation makes sense intuitively, it is simply not true that access to reliable birth control increases adolescent sexual risk-taking.⁴³ In the United States, researchers conducted a study to evaluate what effect direct access to emergency contraception would have on the sexual behaviors of the participants.⁴⁴ While emergency birth control is obviously not the same as a daily hormonal birth control pill, both methods of contraception are hormonal and preventative. This study illustrates the public health impact of the availability of such preventative contraception.⁴⁵

When Plan B first became available over-the-counter, it was restricted to women 17 years old and older.⁴⁶ The Eastern District of New York found that the FDA had “acted in bad faith and in response to political pressure, . . . departed in significant ways from the agency’s normal procedures,” and had justified its age restrictions on reasoning that “lacks all credibility” based on “fanciful and wholly unsubstantiated ‘enforcement’ concerns.”⁴⁷ The court discerned that the arbitrary age restrictions were based on emotional ideals and personal convictions of

42. *Id.*

43. Grossman, *supra* note 9, at 624.

44. Tina R. Raine et al., *Direct Access to Emergency Contraception Through Pharmacies and Effect on Unintended Pregnancy and STIs: A Randomized Controlled Trial*, 293 JAMA 54, 54 (2005).

45. Grossman, *supra* note 9, at 626.

46. *Tummino v. Torti*, 603 F. Supp. 2d 519, 523 (E.D.N.Y. 2009).

47. *Tummino v. Hamburg*, CENTER FOR REPRODUCTIVE RIGHTS, (Aug. 13, 2013) <https://www.reproductiverights.org/case/tummino-v-hamburg>.

top officials that young girls could not understand how to use the emergency contraception without supervision and concerns that young girls would engage in sexual activity if they knew they had the safety net of emergency contraception.⁴⁸ These ideas were most prominently supported by “pro-family” groups that oppose most methods of contraception and not by medical, scientific, or public health organizations.⁴⁹ Charmaine Yoest, President of Americans United for Life, lamented the newfound freedom young women and girls now have over their own reproductive choices, saying;

Parents all across the country ought to be really, really concerned that we’re seeing the Obama administration completely surrender any principle of defending women’s health to the politics of big abortion. There are so many reasons to maintain some measure of control over the distribution of such a strong drug, particularly to young women. I see this as a really, really terrible development. . . . I just think it’s very troubling and sets a really bad standard.⁵⁰

It is not clear what Yoest means by “big abortion.” In reaching its decision, however, the court emphasized that the age restriction was entirely without scientific merit.⁵¹ It would appear that, at least in regard to emergency contraception, science matters.

An increase in access to oral contraception and increase in contraception use does not increase sexual activity among adolescents, which the FDA has learned firsthand by implementing greater access to emergency contraception that did not result in an increase in sexual risk-taking. When first made available to women over 18, researchers found that “there was no relationship between the national policy change and

48. *Id.*

49. Steven Ertelt, *Pro-Life Groups Slam Morning After Pill Ruling: Girls Will be Exploited*, LIFENEWS.COM (Apr. 5, 2013, 10:53 AM), <https://www.lifenews.com/2013/04/05/pro-life-groups-slam-morning-after-pill-ruling-girls-will-be-exploited/>. *Contra* Joerg Dreweke, *Promiscuity Propaganda: Access to Information and Services Does Not Lead to Increases in Sexual Activity*, GUTTMACHER INST. (June 11, 2019) <https://www.guttmacher.org/gpr/2019/06/promiscuity-propaganda-access-information-and-services-does-not-lead-increases-sexual>.

50. Brady Dennis & Sarah Kliff, *Obama Administration Drops Fight to Keep Age Restrictions on Plan B Sales*, WASH. POST, June 10, 2013, https://www.washingtonpost.com/national/health-science/obama-administration-drops-fight-to-keep-age-restrictions-on-plan-b-sales/2013/06/10/a296406e-d22a-11e2-a73e-826d299ff459_story.html?noredirect=on.

51. *Tunmino v. Hamburg*, *supra* note 47.

unprotected sexual activity” for the affected women.⁵² Studies including women and girls under 18 have come to the same conclusion.⁵³

C. Myth: Requiring a Prescription Forces Women to Get Preventive Screening They Would Otherwise Not Seek

Another argument for keeping daily oral contraception off the shelves is that requiring women to see physicians to obtain prescriptions is the most effective way to force them to get preventive screening for certain cancers and diseases.⁵⁴ Those in this camp are of the opinion that it is both necessary and desirable to hold women’s reproductive autonomy hostage in order to impose mandated health screening.⁵⁵ This paternalistic pursuit is both unethical and misguided, as it is not true that obtaining a birth control prescription always requires such testing.⁵⁶ The researchers concluded that there is “clear evidence that neither pharmacy

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52. Danielle N. Atkins & W. David Bradford, *Association Between Increased Emergency Contraception Availability and Risky Sexual Practices*, 50 HEALTH SERV. RES. 809 (2015) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4450931/>.
53. Jennifer L. Meyer et al., *Advance Provision of Emergency Contraception Among Adolescent and Young Adult Women: A Systematic Review of Literature*, J. OF PEDIATRIC & ADOLESCENT GYNECOLOGY, 2011, at 2 (“Most findings indicate that increased use of [emergency contraception] does not have significant negative effects for ongoing contraceptive use or sexual risk taking behaviors.”). *But see* Marvin Belzer et al., *Advance Supply of Emergency Contraception: A Randomized Trial in Adolescent Mothers*, J. OF PEDIATRIC & ADOLESCENT GYNECOLOGY, 2005, at 347 (finding that, in a study of adolescents who were already mothers aged 13 to 20, advance provision of emergency contraception may increase the likelihood of unprotected sex).
54. See Stephenie Mencimer, *Holding Birth Control Hostage*, MOTHER JONES (Apr. 30, 2012), <https://www.motherjones.com/politics/2012/04/doctors-holding-birth-control-hostage/2/> (describing denial of birth control pills if author did not come in for a pelvic exam, contrary to well-accepted guidelines).
55. See Sarah Ruiz-Grossman, *What You Need To Know About Over-The-Counter Birth Control*, HUFFINGTON POST, June 17, 2019, https://www.huffpost.com/entry/birth-control-over-the-counter_n_5d083745e4b0ea7c4a4e6091?guccounter=1&guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xlLmNvbS8&guce_referrer_sig=AQAAAI54Qd6wRaOA-y4B2Z2mihKvhOTAESBl7OYEb7WF6_sD_P1EB70GWnvwDSMwupB_s9exv1bNuRACYSqvWROyy4saf3pEkBJj2g5gnVJBFzlrudWj2or4_P1KUV_jq9cQsY1TW_Wa5dded3QkZ30c55A9mRDYF_yOdl_18FWttYwo (“I think it’s very paternalistic that we hold birth control hostage and force people to come in and get services that are important but unrelated to contraception like forcing them to get a Pap smear or testing for sexually transmitted diseases,’ Grossman said. ‘It just doesn’t make sense. I can’t think of any example in medicine where men are forced to do something like that or they won’t get some other treatment that is unrelated,’ Grossman added.”).
56. See Grossman, *supra* note 9.

access nor advance provision compromises contraceptive or sexual behavior, [therefore] it seems unreasonable to restrict access to emergency contraception to clinics.”⁵⁷

A study conducted in El Paso compared women who obtained their oral contraceptives from clinics in the United States to women who went across the border into Mexico to obtain the drugs without a prescription.⁵⁸ The study concluded that 99 percent of women who obtained oral contraceptives in the United States clinics had undergone cervical cancer screening in the past three years.⁵⁹ One might expect that women who obtained their oral contraceptives in Mexico, without a prescription, would have a much lower rate of screening. Actually, 91 percent of those women obtained cervical cancer screening in the last three years.⁶⁰ Although this is not an insignificant difference, it undermines the theory that withholding oral contraceptives is the only or most effective way to increase screening in women. Both figures, 99 percent and 91 percent, were higher than the national average of 85 percent.⁶¹ These figures mean that women who take oral contraceptives obtain preventative screening at a higher rate than those who do not. This is true even when women are not forced to see a doctor in order to obtain their contraceptives. It would seem that women who take oral contraceptives obtain preventive screening at a higher rate than those who do not, whether they are forced to see a physician to get a prescription or seek screening on their own accord. Women can and do make good health decisions for themselves and should not be compelled to undergo an irrelevant exam to obtain their birth control. The fact remains that there is no medical reason to link pelvic exams to hormonal birth control, and doing so is a paternalistic and outdated practice.⁶² It has been common practice to link the two together, but tradition should not trump a woman’s right to easy access to family planning services, including the use of hormonal birth control.⁶³

57. Raine, *supra* note 44.

58. Kristine Hopkins et al., *Reproductive Health Preventive Screening Among Clinic vs. Over-the-Counter Oral Contraceptive Users*, 86 *CONTRACEPTION* 376 (Oct. 2012).

59. *Id.* at 379.

60. *Id.*

61. *Id.* at 380.

62. Amy Norton, *Women Seeking Birth Control Get Unneeded Pelvic Exams*, *REUTERS*, Nov. 22, 2010, <https://www.reuters.com/article/us-birth-control/women-seeking-birth-control-get-unneeded-pelvic-exams-idUSTRE6AL67X20101122> (“There is no established medical need for women to have the exam before receiving a prescription for birth control pills”).

63. *Id.*

The argument that requiring women to seek prescriptions increases rates of screening might be more persuasive if the same argument were put forth against the insertion of intrauterine devices (IUD) and other long-acting reversible contraceptives (LARC), which can last up to 12 years.⁶⁴ Insertion of those methods necessarily involves a healthcare professional, but women who obtain a form of LARC would not necessarily have to go back to a physician or nurse for screening for several years. Given the apparent discrepancy between what opponents of over the counter access cite to and scientific reality, there are policy concerns being implicated by giving women access and total control over their reproductive autonomy, and, in particular, to young girls who do not need to consult a parent or guardian in order to obtain it. At the very least, opponents are tenaciously holding onto an outdated practice of linking pelvic exams and birth control prescriptions that are misinformed and that disenfranchise women of all ages.⁶⁵

II. JOURNEY TO THE SHELF

To get FDA approval for reclassification of prescription to nonprescription designation, a manufacturer or other sponsor must apply to the Division of Nonprescription Drug Products (“DNNDP”) in the Office of Drug Evaluation at the FDA.⁶⁶ The DNNDP reviews consumer studies, post-marketing safety data, labeling, and any regulatory issues.⁶⁷ If a drug meets the qualifications laid out in the 1951 Durham-Humphrey Amendments to the 1938 Federal Food, Drug, and Cosmetic Act, it may receive over-the-counter designation.⁶⁸ The drug must show that it does not meet the threshold for a mandatory prescription requirement, defined by section 503(b)(4) as:

A drug intended for use by man which-

- (A) is a habit-forming drug to which section 502(d) applies;
- or
- (B) because of its toxicity or other potentiality for harmful effect or the method of its use, or the collateral method neces-

64. See Grossman, *supra* note 9.

65. See Norton, *supra* note 62.

66. OTC Drugs, *How Drugs are Developed and Approved*, U.S. FOOD & DRUG ADMINISTRATION (Nov. 3, 2016), <https://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ucm209647.htm>.

67. *Id.*

68. *Id.*

sary to its use, is not safe for use except under the supervision of a practitioner licensed by law to administer such drug; or (C) is limited by an approved application under section 505 to use under the professional supervision of a practitioner licensed by law to administer such drug.⁶⁹

Durham-Humphrey Amendments of 1951, Pub. L. No. 82-215 (1951) (amended 1997). Once a drug receives this designation, its advertising is regulated by the Federal Trade Commission rather than the FDA, but the FDA maintains regulatory power over the “Drug Facts” label used to educate and instruct consumers.⁷⁰ The label must include information about the inactive and active ingredients, indications and purpose, safety warnings, and directions.⁷¹

Breaking this information down, oral contraceptives must be shown to be non-habit forming and that they can be used safely without supervision by health care professionals. The re-designation of progestin-only oral contraceptives most likely turns on a showing that they do not require a physician’s supervision to be taken safely and effectively. This will require proving the ability of the consumer to self-diagnose her need to take the drug and recognize the warnings along with her own contraindications.⁷² Below, this Note explains why progestin-only oral contraceptives fit squarely within the FDA guidelines for over-the-counter designation.

A. Individual Women Are the Only People Who Know If They Need Birth Control

Women who take hormonal birth control for pregnancy prevention are obviously able to self-diagnose this need. Individual women are actually the only people who are qualified to determine whether or not they have a need to prevent pregnancy. True, hormonal birth control is prescribed and used for a variety of secondary issues, but this does not necessitate prescription requirements for oral contraceptives’ primary

69. Durham-Humphrey Amendments of 1951, Pub. L. No. 82-215 (1951) (amended 1997).

70. OTC Drugs, *supra* note 66 (describing FDA control over the monograph, which includes labelling).

71. *The Over-the-Counter Medicine Label: Take a Look*, U.S. FOOD & DRUG ADMINISTRATION (Sept. 27, 2017), <https://www.fda.gov/drugs/resources-you-drugs/over-counter-medicine-label-take-look>.

72. Grindlay et al., *supra* note 8.

use. A scheme in which progestin-only birth control is available over-the-counter for its primary use is compatible with a scheme in which doctors direct patients to buy and take them for other secondary uses. A similar scheme exists with aspirin; aspirin is one of the most recognizable drugs on the shelf and doctors often instruct patients to take a daily aspirin pill to lower the risk of heart attack or stroke.⁷³

Ultimately, women themselves must decide what types of birth control are right for them. Individual autonomy and the fundamental right to privacy necessitates recognizing a woman's choice of birth control method, whether it be tubal ligation, an intrauterine device, hormonal birth control, the rhythm method, or anything in between.⁷⁴ These decisions are protected from governmental intrusion.⁷⁵

B. *A Growing Number of Medical Professionals Think Oral Contraceptives Need Only Minimal Screening*

The following professional medical organizations have expressed support for making oral contraceptives (not necessarily progestin-only pills) available over-the-counter in some capacity: The American Academy of Family Physicians, the American College of Nurse-Midwives, the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association, the American Public Health Association, the Association of Reproductive Health Professionals, the National Association of Nurse Practitioners in Women's Health, the Society of General Internal Medicine Women's Health Task Force, and the Women's Health Practice and Research Network of the American College of Clinical Pharmacy.⁷⁶ This is not an exhaustive list.

ACOG issued a committee opinion in 2012, stating, "[w]eighing the risks versus the benefits based on currently available data, [oral contraceptives] should be available over-the-counter. Women should self-screen for most contraindications to [oral contraceptives] using checklists."⁷⁷ In so stating, ACOG found that non-physicians are able to

73. Mayo Clinic Staff, *Daily Aspirin Therapy: Understand the Benefits and Risks*, *Patient Care & Health Info*, MAYO CLINIC (Nov. 3, 2015), <https://www.mayoclinic.org/diseases-conditions/heart-disease/in-depth/daily-aspirin-therapy/art-20046797>.

74. *Griswold v. Connecticut*, 381 U.S. 479, 483 (1965).

75. *Griswold*, 381 U.S. at 483.

76. Grossman, *supra* note 9, at 626.

77. THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGISTS, COMMITTEE OPINION ON OVER-THE-COUNTER ACCESS TO ORAL CONTRACEPTIVES (Dec. 2012), <https://www.acog.org/Resources-And-Publications/Committee->

screen themselves for contraindications to oral contraceptives. This opinion is based on a study that found 392 of the 399 patient and health care provider pairs were in agreement on medical eligibility criteria.⁷⁸ These women ranged in age from 15 to 45 years old.⁷⁹ In cases of disagreement, female patients were actually more likely to report a contraindication than were the physicians, suggesting that consumers of hormonal birth control are cautious or even overly-cautious about potential health risks.⁸⁰

*C. Relatively Few Women Have Medical Contraindications to
Hormonal Birth Control*

In a study published by the American Journal of Obstetrics and Gynecology, 5,087 women were analyzed for contraindications to oral contraceptives.⁸¹ Of those 5,087 women, 1,010 women wanted a combined hormonal contraceptive.⁸² Of those 1,010 women, 70 self-identified as having a contraindication to combined hormonal contraceptives.⁸³ Of those 70 self-identifying women, only 24 actually had confirmed medical contraindications—only two percent of the participants.⁸⁴ The study went on to compare this rate to the rate of consumers who develop serious medical side effects to nonsteroidal anti-inflammatory drugs (over-the-counter pain-killers such as ibuprofen and naproxen).⁸⁵ That rate is two to four percent.⁸⁶ Both of these rates represent an occurrence of low prevalence of medical contraindications.

Given that this study involved combined hormonal oral contraceptives, it follows that a progestin-only pill would have similar or even lower rates of contraindications. Progestin-only pills are often prescribed

Opinions/Committee-on-Gynecologic-Practice/Over-the-Counter-Access-to-Oral-
Contraceptives.

78. *Id.*

79. *Id.*

80. *Id.*

81. Xu et al., *supra* note 19, at 210.e2.

82. *Id.*

83. *Id.*

84. *Id.*

85. *Id.* at 210.e4; *Non-Steroidal Anti-Inflammatory Medicines (NSAIDs)*, CLEVELAND CLINIC, <https://my.clevelandclinic.org/health/drugs/11086-non-steroidal-anti-inflammatory-medicines-nsaids> (last reviewed on Apr. 27, 2016).

86. Xu et al., *supra* note 19, at 204.e4.

to women who are considered high-risk, such as women with histories of venous thromboembolism, myocardial infarction, or stroke.⁸⁷

Women are more likely to err on the side of caution when assessing their own contraindications than even physicians are.⁸⁸ In prescribing oral contraceptives, most physicians simply take patients' blood pressure and ask about health history.⁸⁹ Even confirmed rates of contraindications to oral contraceptives are low and within the range of other medications already available over-the-counter.⁹⁰

D. Most Women Live in Countries with Over-the-Counter Oral Contraceptive Access

Most women live in countries with over-the-counter access to oral contraceptives.⁹¹ In a survey of 147 countries by Ibis Reproductive Health, a non-profit reproductive health research center, nearly 70 percent of the surveyed nations offered oral contraceptives without prescription in some capacity (legally or informally, with or without screening).⁹² Some of the nations with the most accessibility are Bangladesh, China, El Salvador, Ethiopia, Greece, India, South Korea, and Ukraine.⁹³ Notably, the United States, Canada, and most of Western Europe require prescriptions.⁹⁴ It follows that the majority of women live in regulatory regimes which believe hormonal birth control pills to be relatively simple and safe drugs not requiring physicians' supervision.

87. Committee on Practice Bulletins—Gynecology, *Use of Hormonal Contraception in Women With Coexisting Medical Conditions*, 133 *OBSTETRICS & GYNECOLOGY* e128, e130 (2019).

88. In a study of 1,010 women desiring combined hormonal birth control, 70 self-reported a possible contraindication. Of those 70, only 24 were found to have a contraindication when a physician reviewed their medical information. Xu et al., *supra* note 19, at 210.e4.

89. Grossman, *supra* note 9, at 625.

90. Xu et al., *supra* note 19, at 210.e1–210.e2.

91. Grindlay et al., *supra* note 8, at 93.

92. *Id.*

93. *Id.* at 4. But note that this survey does not speak to the actual, everyday access women in these countries have to birth control; this study reported only the regulatory schemes of these countries.

94. *Id.*

E. *Hormonal Birth Control Instructions Are Simple Enough for Consumers to Follow*

The basics of taking a progestin-only pill are very simple: take a pill at the same time every day for as long as you want to avoid pregnancy.⁹⁵

Progestin-only oral contraceptives may be started at any time during a woman's menstrual cycle.⁹⁶ If the woman is menstruating when she starts the pill, she will be immediately protected from pregnancy.⁹⁷ If she is not menstruating, she should use alternative contraception for two days.⁹⁸ Consumers must take it at the same time every day within a three-hour window.⁹⁹ If a consumer misses her pill by more than three hours, she should use a backup method of birth control for two days.¹⁰⁰ Unlike combined hormonal oral contraceptives, progestin-only pills do not contain inactive or "placebo" pills; each pill is an active dose of progestin and consumers should not take a break between monthly packs.¹⁰¹

Before approving over-the-counter hormonal birth control, the FDA will require a consumer use study, the purpose of which is to ascertain whether the drug is safe and effective for over-the-counter use.¹⁰² The consumer use study considers consumers' ability to follow labels, directions, and warnings.¹⁰³ This will likely consist of a showing that a majority of women take the pill daily at the same time and follow other instructions like backup contraception in the event of a missed pill.¹⁰⁴ If the progestin-only pill is intended to be for women of all ages, the sponsor will have to show that women of all ages can follow the directions.¹⁰⁵

Women have shown themselves to be adept users of oral contraceptives, and in 15 states plus Washington D.C., the boundaries of the

95. *Minipill (Progestin-Only Birth Control Pill)*, MAYO CLINIC (Mar. 2, 2018), <https://www.mayoclinic.org/tests-procedures/minipill/about/pac-20388306>.

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

102. Consumer Healthcare Prods. Ass'n, *Briefing Information on the Rx-to-OTC Switch Process*, 10 (2012) <https://www.chpa.org/PDF/SwitchProcess.aspx> ("The purpose of a consumer (actual) use study is to simulate the use of a product in a 'real world' setting using a market-ready package. Consumer use studies can assess: (1) compliance, or adherence, with the product labeling; (2) ability to deselect or stop use as directed by the label and (3) safety during actual consumer use.")

103. *Id.*

104. *Id.*

105. *See id.*

FDA's control are being tested. Called "the Uber for Birth Control," a company called Nurx connects consumers to physicians through a phone app.¹⁰⁶ Users are directed to click through a short questionnaire about medical history: Do you have high blood pressure? A history of blood clots? Do you struggle with or want to prevent acne? After just a few clicks, the user is informed that medical professionals will look over her survey information and choose a suitable prescription for her.¹⁰⁷ Once selected, the oral contraceptive is delivered right to the woman's door every month without her ever having to speak to a physician.¹⁰⁸ If she wants to, she may chat with her prescribing doctor or ask questions, but it is far from necessary.¹⁰⁹ Nurx will continue to deliver the prescription drugs every month and accepts insurance, and it also offers emergency contraception like Plan B.¹¹⁰ A woman using the Nurx app relies entirely upon herself to read and answer questions about her health history.¹¹¹ This screening is done legally and efficiently in the states Nurx operates because it is technically done through a physician, although the woman need not speak to a physician directly at all. Preventing women from performing the exact same tasks to achieve the same function—the birth control of her choice—defies logic.

III. THE POLICY BEHIND IT ALL

A. *A Brief History of Birth Control—Clues to the Question*

The history of birth control is a diametrically opposed story of both female empowerment and disenfranchisement. Since at least the beginning of recorded history, humans have struggled to satisfy sexual urges while controlling fertility. Ancient Egyptian women used a mix-

106. Elizabeth Chuck, *Can Nurx, the 'Uber for Birth Control,' Help Women in the Nation's Contraceptive Deserts?*, NBC NEWS (Oct. 24, 2017 4:51 PM), <https://www.nbcnews.com/health/womens-health/can-nurx-uber-birth-control-help-women-nation-s-contraceptive-n813786>.

107. NURX, *Help Me Find What's Right*, <https://app.nurx.com/services> (last visited Sep. 10, 2019) (directing users to answer questions to determine which pills to offer them).

108. Chuck, *supra* note 106.

109. See NURX, *Our Team is Always Here*, <https://www.nurx.com> (last visited Aug. 26, 2019) ("Unexpected side effects? Insurance drama? Our medical team is ready to answer any and all of your questions. If you're unsure about something, just drop us a message.").

110. Chuck, *supra* note 106.

111. See NURX, *supra* note 107.

ture of cotton, dates, honey, and acacia as a suppository to prevent pregnancy.¹¹² The Old Testament and the Koran both refer to *coitus interruptus*, also known as the withdrawal method.¹¹³ But the relevant story begins in 1951, when reproductive activist Margaret Sanger¹¹⁴ and endocrinologist Gregory Pincus met at a dinner party and concocted the birth control pill.¹¹⁵ On a parallel timeline, Mexican chemist Carl Djerassi created a hormonal birth control pill but was unable to test or produce it.¹¹⁶ Pincus's pill worked on the 50 Massachusetts women he tested it on.¹¹⁷ Large-scale testing had to take place in Puerto Rico, where there were no anti-birth control laws on the books.¹¹⁸ It was deemed to be 100 percent effective, and the FDA approved it for severe menstrual disorders.¹¹⁹ The pill was not officially approved as a contraceptive until 1960.¹²⁰ After just two years, 1.2 million American women were taking an oral contraceptive.¹²¹ After three years, the number

112. Alexandra Nikolchev, *A Brief History of the Birth Control Pill*, DETROIT PUB. TV (May 7, 2010), <http://www.pbs.org/wnet/need-to-know/health/a-brief-history-of-the-birth-control-pill/480/>.

113. *Id.*

114. It is worth acknowledging that many view Margaret Sanger as both a racist and a proponent of eugenics. Much of this reputation comes from a letter she penned in 1939 explaining her plan to reach out to African American ministers in the south. She wrote, "We do not want word to go out that we want to exterminate the Negro population, and the minister is the man who can straighten out that idea if it ever occurs to any of their more rebellious members." Regardless of whether this is a fair depiction of her beliefs as a whole, Sanger's role in contraceptive activism was a large one. See *Birth Control or Race Control? Sanger and the Negro Project*, THE NEWSL. (NYU/Margaret Sanger Papers Project, New York, N.Y.), Fall 2001, https://www.nyu.edu/projects/sanger/articles/bc_or_race_control.php.

115. Nikolchev, *supra* note 112.

116. *Id.*

117. *Id.*

118. This large-scale testing was conducted coercively on women in Puerto Rico, where there were no legal restrictions on birth control and the government turned a blind eye to unethical clinical practices. See Erin Blakemore, *The First Birth Control Pill Used Puerto Rican Women as Guinea Pigs*, HISTORY (Mar. 11, 2019), <https://www.history.com/news/birth-control-pill-history-puerto-rico-enovid>; Yara Simón, *Revisiting the Dark History of Birth Control Testing in Puerto Rico*, REMEZCLA (Nov. 4, 2016, 1:51 PM), <https://remezcla.com/culture/birth-control-testing-puerto-rico/>; Theresa Vargas, *Guinea Pigs or Pioneers? How Puerto Rican Women Were Used to Test the Birth Control Pill*, WASH. POST (May 9, 2017), <https://www.washingtonpost.com/news/retropolis/wp/2017/05/09/guinea-pigs-or-pioneers-how-puerto-rican-women-were-used-to-test-the-birth-control-pill/>.

119. Nikolchev, *supra* note 112.

120. *Id.*

121. *Id.*

jumped to 2.3 million.¹²² The pill was still illegal in eight states.¹²³ In 1965, the Supreme Court decided *Griswold v. Connecticut* and ruled that Connecticut's ban on the use or encouragement of birth control violated the right to *marital* privacy.¹²⁴

In 1968, Pope Paul VI authored the *Humanae Vitae* (in English: *Of Human Life*).¹²⁵ In it, His Holiness reiterated the Catholic canon of sex only within marriage and for the sole purpose of procreation (although *Humanae Vitae* makes an exception for the rhythm method).¹²⁶ It is an outright condemnation of "artificial" birth control.¹²⁷ In 1970, the Senate conducted hearings on the safety of the pill, but the hearings were interrupted by women demanding a voice on the issue.¹²⁸ In 1972, The Supreme Court decided another case involving birth control, this time with implications for non-married people.¹²⁹ In *Eisenstadt v. Baird*, the Court established the right of *unmarried* people to use contraception on the same basis as married people.¹³⁰ Despite the greenlight for everyone to use contraception, bad publicity regarding potential side effects caused sales of the pill to drop by 24 percent by 1979.¹³¹

But by 1988, the pill was back with a vengeance. A second generation of pills with lower doses of hormones decreased health risks and even provided some health benefits like decreased risk of ovarian cancer and pelvic inflammatory disease.¹³²

Cut to 2014, where the Supreme Court once again ruled on a contraceptive issue. This time, the Court ruled in favor of decreased access to birth control for women by finding that corporations run on religious

122. *Id.*

123. *Id.*

124. *Griswold v. Connecticut*, 381 U.S. 479, 483 (1965).

125. See POPE PAUL VI, *HUMANAE VITAE: ENCYCLICAL LETTER OF HIS HOLINESS POPE PAUL VI, ON THE REGULATION OF BIRTHS* (Marc Caligari trans., Ignatius Press) (1968).

126. *Id.* at 14. ("If, then, there are serious motives for spacing births, motives deriving from the physical or psychological condition of husband or wife, or from external circumstances, the Church teaches that it is then permissible to take into account the natural rhythms immanent in the generative functions and to make use of marriage during the infertile times only, and in this way to regulate births without offending the moral principles that we have just recalled.").

127. Artificial birth control is any form of contraception other than the rhythm method.

128. Nikolchev, *supra* note 112.

129. *Eisenstadt v. Baird*, 405 U.S. 438, 447 (1972).

130. *Eisenstadt*, 405 U.S. at 447.

131. Nikolchev, *supra* note 112. Potential side effects of hormonal birth control were revealed, including the risk of blood clots, heart attack, stroke, depression, weight gain, and loss of libido.

132. *Id.*

principles do not have to pay for insurance coverage for contraception for their employees.¹³³ All three female members of the Court dissented from the majority.¹³⁴ While this decision shut the door for many women and made it harder to obtain contraception, it does not directly affect women without health insurance, for obvious reasons. The *Burwell* decision widened the pool of women who are forced to either simply forego contraception or turn to less-effective or less-preferred methods because the prescription requirement is an insurmountable barrier.

B. *Effect on Indigent, Minority, and Young Women*

Nearly half of all pregnancies each year in the United States are unplanned.¹³⁵ The primary cause of unplanned pregnancy in the United States is lack of contraception.¹³⁶ There are stark demographic and socio-economic differences hiding in these statistics.¹³⁷ Notably, unintended pregnancy rates are highest among women with incomes less than 200 percent of the federal poverty level and the rates for black women are more than double the rates for white women.¹³⁸ In spite of these statistics, women without access to physicians nonetheless obtain oral contraceptives through means other than prescriptions.

Seeing a physician to obtain oral contraceptives is time-consuming and unnecessary, and it can be expensive.¹³⁹ These barriers affect women of color, poor women, and young women the hardest.¹⁴⁰ Seeing a physician can require women to seek and pay for childcare, take time off of work, or miss other opportunities just to obtain a prescription that is not even deemed necessary in other developed countries.

The most striking examples of these barriers are found in rural areas. Rural communities can be “contraception deserts” when it comes to oral contraceptives.¹⁴¹ Denicia Cadena, policy director of a New Mexico-based organization called Young Women United, points out that patients in rural communities often face three- to six-month wait times for

133. *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 687 (2014).

134. *Burwell*, 573 U.S. at 740–72.

135. See *Unintended Pregnancy in the United States*, GUTMACHER INSTITUTE (Jan. 2019), <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>.

136. *Id.*

137. *Id.*

138. *Id.*

139. See Chuck, *supra* note 106.

140. See Howard & Starrs, *supra* note 11.

141. Chuck, *supra* note 106.

primary care and even longer for specialty care, like gynecology.¹⁴² This causes women to experience unacceptable lapses in their birth control because oral contraceptives must be taken daily without interruption (besides the inactive pills) in order to be effective.¹⁴³ Even if a woman overcomes the large barrier of getting to a physician in the first place, the doctor might not understand her language or be able to provide culturally-competent care.¹⁴⁴ This can lead to misunderstanding and confusion in a healthcare system that is already expensive to enter and complicated to navigate.

IV. THE UNCONSTITUTIONALITY OF THE CURRENT BIRTH CONTROL REGIME

While prescription birth control requirements further harmful social policy, there is also a strong argument that they are unconstitutional under the Fifth and Fourteenth Amendment's Due Process clauses. As this section will detail, reproductive autonomy has long been recognized as one of the fundamental privacy rights protected by the Fifth and Fourteenth Amendment's Due Process clauses. Furthermore, based on the Supreme Court's jurisprudence in *Carey v. Population Services*, as well as the abortion cases, prescription birth control requirements embody the type of 'undue burden' the Court has repeatedly found to be unconstitutional.¹⁴⁵

A. Reproductive Autonomy as a Fundamental Right

The Fifth Amendment of the United States Constitution, in conjunction with the Fourteenth Amendment, prohibits federal or state action that deprives citizens of "life, liberty, and property, without due process of law."¹⁴⁶ The Due Process clause guarantees citizens two broad

142. Katie Klabusich, *Advocates Set Sights on OTC Birth Control Pill on World Contraception Day*, REWIRE.NEWS (Sep. 26, 2017, 3:49 PM), <https://rewire.news/article/2017/09/26/advocates-set-sights-otc-birth-control-pill-world-contraception-day>.

143. Mayo Clinic Staff, *supra* note 95.

144. *Disparities in Health Care Quality Among Racial and Ethnic Minority Groups: Selected Findings From the 2010 National Healthcare Quality and Disparities Reports*, AHRQ, (Apr. 2011), <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqdr/nhqdr10/minority.pdf>.

145. *Carey v. Population Services*, 431 U.S. 678, 685 (1977) (compiling caselaw regarding right to beget a child as important aspect of right to privacy).

146. U.S. CONST. amend. V, XIV.

classes of rights. First, it requires that the government institute fair procedures before taking away a citizen's rights.¹⁴⁷ More relevantly to the discussion of this article, the Due Process clause protects "fundamental rights" through the doctrine of substantive due process.¹⁴⁸ Under this theory, even the fairest government proceedings do not provide due process if they result in the deprivation of certain rights which "have been found to be implicit in the concept of ordered liberty."¹⁴⁹

Although various formulations have been offered to define exactly which rights fall under this schema, almost all have recognized that the right to privacy is granted heightened protection through substantive due process.¹⁵⁰ American courts have found this right to privacy encompasses the right of individuals to control their own reproductive outcomes.¹⁵¹ The first major Supreme Court case to enshrine a substantive right to privacy dealt with a Connecticut law that prohibited individuals from using birth control.¹⁵² In *Griswold v. Connecticut*, the Supreme Court overturned the convictions of two doctors who had advised married couples on the use of contraceptives. In doing so, the Court found that a right of privacy—which protected the intimate relations of married couples from government interference—was created through implication by the Bill of Rights.¹⁵³ In reaching this conclusion, the Court looked to the First Amendment's protection of the right to associate, the Third Amendment's prohibition on the quartering of soldiers, the Fourth Amendment's prohibition against unreasonable searches and seizures, the Fifth Amendment's protection against self-incrimination, and the Ninth Amendment's reservation of all non-enumerated privileges back to the people to prove that the Constitution recognized there were "zones of privacy" into which the government could not intrude.¹⁵⁴ Marital privacy, the Court found, was "a right of privacy older than the

147. See, e.g., *Marchant v. Pennsylvania R.R.*, 153 U.S. 380, 385–86 (1894); *Hagar v. Reclamation Dist.*, 111 U.S. 701, 708 (1884); *Hurtado v. California*, 110 U.S. 516, 537 (1884); *Medina v. California* 505 U.S. 437, 443 (1992).

148. See *Palko v. Connecticut*, 302 U.S. 319, 324–25 (1937).

149. *Palko*, 302 U.S. at 325.

150. See, e.g., *Carey*, 431 U.S. at 684–85.

151. E.g., *Carey*, 431 U.S. at 685 ("The decision whether or not to beget or bear a child is at the very heart of this cluster of constitutionally protected choices."); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) ("If the right of privacy means anything, it is the right of the individual, married or single, to be free of unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.");

152. *Griswold v. Connecticut*, 381 U.S. 479 (1965).

153. *Griswold*, 381 U.S. at 484.

154. *Griswold*, 381 U.S. at 484.

Bill of Rights—older than our political parties, older than our school system.”¹⁵⁵ This right was violated by a law that prevented marital couples from using contraceptives, and so the law was found to be unconstitutional.¹⁵⁶

Post-*Griswold*, it was not clear whether the case had merely upheld the privacy rights of marital individuals or whether it protected a wholly different set of privacy rights—that of citizens to control their own contraceptive outcomes. In *Eisenstadt v. Baird*, the Supreme Court substantially clarified its jurisprudence.¹⁵⁷ *Eisenstadt* involved the arrest of a Massachusetts doctor who had, among other things, prescribed vaginal foam to a female student at Boston University.¹⁵⁸ Massachusetts at the time prohibited the distribution of contraceptives to anyone unless they were married.¹⁵⁹ In striking down the law, the Supreme Court held that the Massachusetts law violated both the Equal Protection Clause and Substantive Due Process.¹⁶⁰ As the Court explained, if “*Griswold* is no bar to a prohibition on the distribution of contraceptives,” Massachusetts still violated the Equal Protection Clause by prohibiting contraceptive use by married individuals but not by single people.¹⁶¹ Alternatively, if *Griswold* enshrined a right for individuals to make their own reproductive decisions, then the decision to exclude single people was arbitrary.¹⁶² As the court concluded, “if the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”¹⁶³

Five years after *Eisenstadt*, the Supreme Court, in *Carey v. Population Services International*, again affirmed that the right for women to access birth control was fundamental.¹⁶⁴ *Carey* involved a challenge to a New York law that, in part, prohibited the distribution of contraceptives by pharmacists unless they were specially licensed by the State.¹⁶⁵ In rejecting the law, the Court began by detailing the privacy interest contraceptive use touched upon.¹⁶⁶ “The decision whether or not to beget or

155. *Griswold*, 381 U.S. at 484.

156. *Griswold*, 381 U.S. at 484.

157. *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

158. *Eisenstadt*, 405 U.S. at 440.

159. *Eisenstadt*, 405 U.S. at 440–41.

160. *Eisenstadt*, 405 U.S. at 454–55.

161. *Eisenstadt*, 405 U.S. at 454.

162. *Eisenstadt*, 405 U.S. at 452–53.

163. *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

164. *See Carey v. Population Servs. Int'l.*, 431 U.S. 678, 687 (1977).

165. *Carey*, 431 U.S. at 681.

166. *Carey*, 431 U.S. at 684–85.

bear a child,” Justice Brennan wrote in the majority opinion, “is at the very heart of [the] cluster of constitutionally protected choices [the Due Process clause protects].”¹⁶⁷ This was “understandable,” Justice Brennan explained, because “in a field that by definition concerns the most intimate of human activities and relationships, decisions whether to accomplish or to prevent conception are among the most private and sensitive.”¹⁶⁸ While New York had argued that *Griswold* was not relevant because it “struck down a state prohibition of the use of contraceptives and so had no occasion to discuss laws regulating their manufacture or sale,” the Court rejected such a narrow interpretation.¹⁶⁹ “*Griswold*,” it held, “may no longer be read as holding only that a State may not prohibit a married couple’s use of contraceptives.”¹⁷⁰ Instead, “read in light of its progeny,” the Court concluded, “the teaching of *Griswold* is that the Constitution protects individual decisions in matters of childbearing from unjustified intrusion by the State.”¹⁷¹

B. Reproductive Rights and the Undue Burden Standard

While the Supreme Court applied strict scrutiny to reproductive rights cases as early as *Griswold*, the *Carey* court faced a law that did not altogether prohibit contraceptive use but instead restricted its availability. The court deployed one of the first iterations of the undue burden test to determine whether New York’s law was constitutional. Looking to the abortion cases of the mid 1970s, the *Carey* court noted that “the significance of these cases is that they establish that the same test must be applied to state regulations that burden an individual’s right to decide to prevent conception or terminate pregnancy by substantially limiting access to the means of effectuating that decision as is applied to state statutes that prohibit the decision entirely.”¹⁷² “Where a decision as fundamental as that whether to bear or beget a child is involved,” the Court noted, “regulations imposing a *burden* on it may be justified only by compelling state interests, and must be narrowly drawn to express only those interests” (emphasis added).¹⁷³

167. *Carey*, 431 U.S. at 685.

168. *Carey*, 431 U.S. at 685.

169. *Carey v. Population Servs. Int’l.*, 431 U.S. 678, 686–87 (1977).

170. *Carey*, 431 U.S. at 687.

171. *Carey*, 431 U.S. at 687.

172. *Carey*, 431 U.S. at 688.

173. *Carey*, 431 U.S. at 686.

Applying this test to New York's law, the Court found the burden imposed by the law on women's access to birth control was substantial.¹⁷⁴ Although the burden of New York's law was not "of course . . . as great as that under a total ban on distribution," the Court observed that the "restriction of distribution channels" for birth control made contraceptives "less accessible to the public, reduce[d] the opportunity for privacy of selection and purchase, and lessen[ed] the possibility of price competition."¹⁷⁵ None of the State's proffered interests—female health, protection of potential life, maintaining quality control, and ease of enforcement—were deemed compelling. Although the *Carey* court's ruling only applied to non-prescription contraceptives, it laid out the framework by which the undue burden test could be applied to reproductive rights cases.

Fifteen years after *Carey*, the Supreme Court again turned to the undue burden test in *Planned Parenthood of South East Pennsylvania v. Casey*.¹⁷⁶ *Casey* involved a Pennsylvania law that, in part, required informed consent and a 24-hour waiting period for all women seeking to receive an abortion and informed consent from a parent of any minor seeking an abortion.¹⁷⁷ Additionally, it required married women to notify their husbands of their intent to abort a fetus before procuring the procedure.¹⁷⁸ While many expected the Supreme Court to overturn *Roe v. Wade* through *Casey*, instead, the *Casey* court upheld *Roe*'s central holding—that a woman's right to terminate her pregnancy was protected by substantive due process—while replacing *Roe*'s trimester framework with the undue burden test.¹⁷⁹

In her landmark majority opinion, Justice O'Connor began by reaffirming the expansive scope of substantive due process. "Neither the Bill of Rights nor the specific practices of states at the time of the adoption of the Fourteenth Amendment," she remarked, "marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects."¹⁸⁰ This protection, she observed, "was extended to the sale and distribution of contraceptives in *Carey v. Population Services International*."¹⁸¹ Justice O'Connor concluded, "it is settled now, as it was when the Court heard arguments in *Roe v. Wade*, that the Con-

174. *Carey v. Population Servs. Int'l.*, 431 U.S. 678, 689 (1977).

175. *Carey*, 431 U.S. at 689.

176. *Planned Parenthood v. Casey*, 505 U.S. 833, 843 (1992).

177. *Casey*, 505 U.S. at 844.

178. *Casey*, 505 U.S. at 844.

179. *Casey*, 505 U.S. at 873–74.

180. *Casey*, 505 U.S. at 848.

181. *Planned Parenthood v. Casey*, 505 U.S. 833, 849 (1992).

stitution places limits on a state's right to interfere with a person's most basic decisions about family and parenthood."¹⁸²

Turning to the proper standard by which to evaluate potential restrictions on a woman's reproductive rights, Justice O'Connor introduced the undue burden test. "A finding of an undue burden," she explained, "is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."¹⁸³ As such, a statute which, "while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice," cannot be "considered a permissible means of serving its legitimate ends."¹⁸⁴ Ultimately, the *Casey* court upheld three of the Pennsylvania requirements, while invalidating the provision requiring women notify their husbands before procuring an abortion. In light of the severe risk of abuse women could face by having to notify their husbands of their plan to abort, the *Casey* court found a substantial obstacle was created, which constituted an unconstitutional burden.¹⁸⁵

Almost 25 years after *Casey*, the Supreme Court revisited the undue burden test once more in *Whole Woman's Health v. Hellerstedt*.¹⁸⁶ *Hellerstedt* challenged a set of Texas regulations which required, first, that doctors who performed abortions had admitting privileges with a hospital within 30 miles from the abortion facility, and second, that abortion facilities met minimum standards for ambulatory surgical centers.¹⁸⁷ As a result of the Texas bill, evidence produced in lower level proceedings showed that half of Texas's abortion clinics were unable to comply with the new regulations and had shut down, and, with full enforcement of the bill, another ten out of the original forty would be shuttered.¹⁸⁸ Furthermore, the evidence record demonstrated that between November 1, 2012 and May 1, 2014, that is, before and after enforcement of the admitting-privileges requirement:

The decrease in geographical distribution of abortion facilities has meant that the number of women of reproductive age living more than 50 miles from a clinic has doubled (from

182. *Casey*, 505 U.S. at 849.

183. *Casey*, 505 U.S. at 877.

184. *Casey*, 505 U.S. at 877.

185. *Casey*, 505 U.S. at 887–95.

186. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016 revised June 27, 2016).

187. *Whole Woman's Health*, 136 S. Ct. at 2300.

188. *Whole Woman's Health*, 136 S. Ct. at 2301, 2310–14.

800,000 to over 1.6 million); those living more than 100 miles has increased by 150 [percent] (from 400,000 to 1 million); those living more than 150 miles has increased by more than 350 [percent] (from 86,000 to 400,000); and those living more than 200 miles has increased by about 2,800 [percent] (from 10,000 to 290,000). After September 2014, should the surgical-center requirement go into effect, the number of women of reproductive age living significant distances from an abortion provider will increase as follows: 2 million women of reproductive age will live more than 50 miles from an abortion provider; 1.3 million will live more than 100 miles from an abortion provider; 900,000 will live more than 150 miles from an abortion provider; and 750,000 more than 200 miles from an abortion provider.¹⁸⁹

In assessing whether the Texas law passed constitutional muster, Justice Breyer again turned to the undue burden test, finding both requirements unconstitutionally erected barriers to women's reproductive rights.¹⁹⁰ Analyzing the admitting privileges requirement, the court found the state's proffered justification for the law—to help ensure that women have easy access to a hospital should complications arise during an abortion procedure—did not outweigh the burden it placed on women seeking abortions in Texas.¹⁹¹ Indeed, the Court highlighted that the medical benefit proffered by the state was largely illusory, agreeing with the district court's conclusion that “before the act's passage, abortion in Texas was extremely safe with particularly low rates of serious complications and virtually no deaths occurring on account of the procedure.”¹⁹² Therefore, the Court concluded the new law did not “advance[. . .] Texas' legitimate interest in protecting *women's health*.”¹⁹³ Rather, the Court found the law had the effect of shuttering abortion clinics across the State by adding an onerous extra hiring requirement for every doctor employed by an abortion clinic.¹⁹⁴ In doing so, women in the state faced “fewer doctors, longer waiting times, and increased crowding.”¹⁹⁵ Similarly, the law led to geographic concentration of abor-

189. *Whole Woman's Health*, 136 S. Ct. at 2302.

190. *Whole Woman's Health*, 136 S. Ct. at 2300.

191. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2311-12 (2016 revised June 27, 2016).

192. *Whole Woman's Health*, 136 S. Ct. at 2311.

193. *Whole Woman's Health*, 136 S. Ct. at 2311.

194. *Whole Woman's Health*, 136 S. Ct. at 2317.

195. *Whole Woman's Health*, 136 S. Ct. at 2313.

tion clinics to a few major metropolitan cities in Texas, meaning tens of thousands of Texas women would be hundreds of miles away from an abortion provider.¹⁹⁶ While acknowledging that “increased driving distances do not always constitute an undue burden,” the Court held that those extra distances, “taken together with [other burdens] that the closings brought about, and when viewed in light of the virtual absence of any health benefit, lead us to conclude that the record adequately supports the District Court’s ‘undue burden’ conclusion.”¹⁹⁷ On those grounds, the admitting privileges doctrine was found to constitute an undue burden and was struck down.¹⁹⁸

In rejecting Texas’ requirement that abortion facilities meet the same medical standards as ambulatory surgical centers, the Court followed a similar approach. First, it rejected Texas’s contention that the requirement helped make abortions safer.¹⁹⁹ Again, it looked to the record for evidence that demonstrated that abortion procedures in Texas were remarkably safe already, affirming the district court’s conclusion that “risks are not appreciably lowered for patients who undergo abortions at ambulatory surgical centers as compared to nonsurgical-center facilities.”²⁰⁰ Additionally, the Court expressed skepticism at Texas’ proffered concern about patient health in light of the fact that there were numerous more dangerous procedures which were not subjected to the ambulatory surgical center requirement.²⁰¹ As the Court observed:

The total number of deaths in Texas from abortions was five in the period from 2001 to 2012, or about one every two years (that is to say, one out of about 120,000 to 144,000 abortions). *Id.*, at 272. Nationwide, childbirth is 14 times more likely than abortion to result in death, but Texas law allows a midwife to oversee childbirth in the patient’s own home. Colonoscopy, a procedure that typically takes place outside a hospital (or surgical center) setting, has a mortality rate 10 times higher than an abortion. *Id.*, at 276–277; see ACOG Brief 15 (the mortality rate for liposuction, another

196. *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2296 (2016 revised June 27, 2016).

197. *See Whole Woman’s Health*, 136 S. Ct. at 2301–02.

198. *Whole Woman’s Health*, 136 S. Ct. at 2313.

199. *See Whole Woman’s Health*, 136 S. Ct. at 2298–99.

200. *Whole Woman’s Health*, 136 S. Ct. at 2315.

201. *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2315 (2016 revised June 27, 2016).

outpatient procedure, is 28 times higher than the mortality rate for abortion).²⁰²

These facts, the Court concluded, “indicate that the surgical-center provision imposes a requirement that simply is not based on differences between abortion and other surgical procedures that are reasonably related to preserving women’s health, the asserted purpos[e] of the Act in which it is found.”²⁰³ (quotations omitted).

At one point during oral argument, the Attorney General of Texas is asked by Justice Kagan why Texas chose to set much higher medical standards for abortions than for other more dangerous procedures, such as colonoscopies and liposuction.²⁰⁴ The Attorney General repeatedly replied that these regulations were well within the legislature’s exercise of power, and that the legislature was free to respond to areas of public concern, such as abortion, implying that the legislature was also free to ignore riskier but less controversial procedures, such as those Justice Kagan mentioned.²⁰⁵ This particular exchange is one example of both the inconsistencies in Texas’ legislation, and of ways in which legislatures take unnecessary steps to regulate women’s reproductive autonomy to serve political agendas.

While the Court rejected the health benefit claimed by the requirements, it again highlighted the enormous obstacle the requirements placed on women’s access to their reproductive rights. “In the face of no threat to women’s health,” the Court noted, “Texas seeks to force women to travel long distances to get abortions in crammed-to-capacity superfacilities.”²⁰⁶ In light of the decreased quality of care that would ensue, as well as the lack of access many women would face, the Court found the second requirement also unconstitutional.

202. *Whole Woman’s Health*, 136 S. Ct. at 2315.

203. *Whole Woman’s Health*, 136 S. Ct. at 2315.

204. Transcript of Oral Argument at 51:12–14, *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) (No. 15-274) (“[W]e know that liposuction is 30 times more dangerous, yet doesn’t have the same kinds of requirements [as abortion in Texas]”).

205. Transcript of Oral Argument at 68:7–8, *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) (No. 15-274) (“But legislatures react to topics that are of public concern.”).

206. *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2318 (2016 revised June 27, 2016).

*C. Putting it All Together: A Constitutional Attack on
Prescription Birth Control Requirements*

Under the framework outlined by *Griswold*, *Eisenstadt*, *Carey*, *Casey*, and *Whole Women*, prescription requirements for female birth control are constitutionally suspect.

As acknowledged by *Griswold*, *Eisenstadt*, and *Carey*, the right for a woman to use birth control falls squarely within the proverbial zone of privacy that the Due Process Clause protects.²⁰⁷ As Justice O'Connor noted in *Casey*, the decision whether to bear or beget a child "involve[s] the most intimate and personal choices a person may make in a lifetime."²⁰⁸ These choices are "central to personal dignity and autonomy, [and] are central to the liberty protected by Fourteenth Amendment."²⁰⁹

As a fundamental right, a woman's right to use birth control is protected from unjust interference or hindrance by the government. As explained in *Casey*, even if the government has a legitimate aim in enacting a certain law, if that law substantially burdens a woman's access to a fundamental right, it is unconstitutional.²¹⁰

Here, the government has no legitimate interest in creating a prescription requirement for progestin-only birth control. As detailed in this Note, the medical risks associated with progestin-only oral contraceptives are minimal, non-unique, and easily curable with less prohibitive regulations.²¹¹ Furthermore, similar to Justice Breyer's criticism in *Whole Women*, the government's hypothetical assertion that prescription-birth control requirements are necessary to protect female health is undercut by the fact that there are many more dangerous over-the-counter medications available which are not subject to a prescription re-

207. *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965) ("The present case, then, concerns a relationship lying within the zone of privacy created by several fundamental constitutional guarantees."); *Eisenstadt v. Baird*, 405 U.S. 438, 461 (1972) ("[T]he Connecticut law, which forbade using contraceptives or giving advice on the subject, unduly invaded a zone of marital privacy protected by the Bill of Rights."); *Carey v. Population Services, Intern.*, 431 U.S. 678, 684–85 (1977) ("While the outer limits of this aspect of privacy have not been marked by the Court, it is clear that among the decisions that an individual may make without unjustified government interference are personal decisions relating to . . . contraception.") (internal quotations omitted).

208. *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992).

209. *Casey*, 505 U.S. at 851.

210. *See Casey*, 505 U.S. at 877 ("[A] statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends.").

211. *See supra* section I.A.

quirement.²¹² These drugs, like birth control, can be medically harmful if used inappropriately.²¹³ And yet, society has determined that the value of their easy access and their therapeutic benefit is worth that risk. A judgment that easy access to birth control—which is essential not only to female reproductive empowerment but also to female social and economic empowerment—is somehow different is grounded in neither law nor policy, but instead, in outdated norms about female sexuality and female autonomy. The Constitution offers no refuge for such concerns.²¹⁴

While the interest furthered by the prescription birth control requirement is minimal, the burden it places on women is enormous. Access to medical insurance is still limited in the United States, as is comprehensive coverage for gynecological services.²¹⁵ Furthermore, the long wait-times associated with receiving a gynecology appointment, along with the scarcity of gynecologists across the country, means that, for many women, going to the doctor is a non-starter.²¹⁶ These women, of course, do not stop engaging in sexual intercourse. Instead, by creating a massive regulatory barrier to women receiving birth control, the current regime pushes women to engage in unprotected and risky sex, which, in turn, frequently leads to either use of Plan B or abortion procedures. One does not need to squint too hard to see that prescription requirements for birth control actually harm female health. In doing so, they constitute an unconstitutional burden on women's reproductive rights.

212. See *supra* section I.A.

213. See *supra* section I.A.

214. This concept is most clearly illustrated by the unconstitutionality of state laws requiring married women to notify their husbands before getting abortions. See, e.g., *Planned Parenthood v. Casey*, 505 U.S. 833, 897 (1992). (“Only one generation has passed since this Court observed that ‘woman is still regarded as the center of home and family life,’ with attendant ‘special responsibilities’ that precluded full and independent legal status under the Constitution.” (internal citations omitted)).

215. See William F. Rayburn et al., *Distribution of American Congress of Obstetricians and Gynecologists Fellows and Junior Fellows in Practice in the United States*, 119 *OBSTETRICS & GYNECOLOGY* 1017, 1017 (2012) (“In 2010, the 33,624 general obstetrician-gynecologists (ob-gyns) in the United States, comprised 5.0 percent of the total 661,400 physicians. There were 2.65 ob-gyns per 10,000 women and 5.39 ob-gyns per 10,000 reproductive-aged women. The density of ob-gyns declined from metropolitan to micropolitan and to rural counties. Approximately half (1,550, 49 percent) of the 3,143 U.S. counties lacked a single ob-gyn, and 10.1 million women (8.2 percent of all women) lived in those predominantly rural counties. Such counties, located especially in the central and mountain west regions, were commonly in designated Health Professional Shortage Areas.”).

216. See *id.*

CONCLUSION

Throughout history, women have had to take control over their own fertility. From ancient herbal methods, to demanding safer, lower dosage pills, to fighting for the right to use contraception both in and out of marriage. Despite its widespread prevalence, contraceptive use has historically carried with it a taint of un-chastity, un-purity, and un-femininity. Requiring a prescription for a relatively safe and easy to understand drug is a modern vestige of the stigma that has always surrounded female sexuality in western cultures. The barriers to oral contraceptives are unique because oral contraceptives themselves are unique. When they do not require a physician's approval, oral contraceptives represent unburdened, cheap, and effective access to sexual liberation and autonomy that is entirely within a woman's control. Unlike male condoms, the woman takes the pill. Unlike long acting reversible contraceptives, the woman may discontinue use at any time, free of charge. Unlike female sterilization, the woman may choose to become pregnant if she is otherwise able and simply stops taking the pill. With more women obtaining advanced degrees, entering and staying in the workforce, and starting families later, the demand for freer access to oral contraceptives is higher than ever. The stage is set for increased access on the drugstore shelves.

Increased access fits neatly into the existing constitutional framework that unequivocally protects the right to contraception. Analyzing the prescription-only status of progestin-only hormonal birth control within the undue burden framework makes sense given the high financial and opportunity costs of visiting a physician. This is especially true given the number of readily obtainable drugs available without a prescription on the shelves of any drugstore, which actually pose more serious health risks than hormonal birth control. The undue burden test is not only a convenient mechanism for analyzing access to contraception, it is the most logical. ♣