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Access to ella® Emergency Contraception at California Pharmacies

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EXECUTIVE SUMMARY

Emergency contraceptive pills (ECPs) significantly reduce the risk of pregnancy when taken within 3-5 days after unprotected sex. Ulipristal acetate emergency contraception, sold under the brand name ella, is more effective for a longer window of time and at higher body weights than levonorgestrel ECPs like Plan B One-Step. However, ella is prescription-only and is far less available than Plan B, which is offered over the counter at many pharmacies. The limited availability of ella not only creates a general barrier to access for the most effective ECP, but also may especially disadvantage the many people—including 25.1% of Californians assigned female at birth—who weigh 155-187 lbs. (the weight range in which ella is more effective than Plan B).

Providers and advocates have identified increasing access to emergency contraception as a necessary component of efforts to protect reproductive autonomy, particularly amid the post-Dobbs context of proliferating bans and restrictions on abortion. However, prior research has found that many health care providers lack knowledge about ella emergency contraception. California is one of eight states that permits pharmacists to prescribe emergency contraception, and because ella is only available with a prescription, pharmacists are potentially a critical point of access to this medication. This brief draws on data from two sources—a 2022 survey of California pharmacists and the 2020 California Health Interview Survey—to investigate the availability of ella at California community pharmacies and to understand the need for access to ella among people who can get pregnant in California.

KEY FINDINGS

- Only 21% of California community pharmacists reported that their pharmacy provides ella without an outside provider's prescription (i.e., through pharmacist prescription).
- In contrast, 79% of community pharmacists reported that Plan B, which can be sold over the counter, was available without an outside provider's prescription at their pharmacy.

- Pharmacists at pharmacies that furnish hormonal contraception were over four times as likely to report pharmacy provision of ella compared to those at pharmacies that do not prescribe hormonal contraception.
- One in four Californians assigned female at birth weighs between 155-187 lbs., the weight range in which ella is more effective than Plan B, underscoring the need to improve access to this form of emergency contraception.

POLICY RECOMMENDATIONS

- Investigate and address barriers to California pharmacist prescribing of ella.
- Target pharmacists who prescribe hormonal contraception for initiatives aimed at increasing pharmacist prescription of ella.
- Make ella available without a prescription.

INTRODUCTION

Emergency contraceptive pills (ECPs)—colloquially known as the "morning-after pill"—can significantly reduce the risk of pregnancy when taken within 3-5 days after unprotected sex. Among sexually active women in the United States ages 18-49 who do not wish to become pregnant, 17% are not using contraception.[1] In California, 25% of sexually active women ages 18-44 who do not wish to become pregnant are not using contraception.[2] Women of color, those who speak both English and Spanish at home, low-income women, and women who are uninsured, on Medi-Cal, or without a usual source of health care are overrepresented among those not wishing to become pregnant but not using contraception;[3] these populations may face increased barriers to accessing contraception including cost, lack of insurance coverage, and logistical hurdles such as scheduling appointments and traveling to clinics or pharmacies.[4, 5, 6] Reproductive coercion, sexual assault, and situational nonuse or contraceptive failure (e.g., forgetting to take a birth control pill, condom breakage) can occur among those who do ordinarily use contraception, also creating a need for emergency contraception. Indeed, the two most commonly reported reasons for using emergency contraception are not using birth control (50%) and fearing that their usual method would not work (41%).[7] Therefore, emergency contraception can be a critical pregnancy prevention tool both for those who are not using contraception and for those who are.

In the lead-up to the *Dobbs vs. Jackson Women's Health Organization* Supreme Court case, which ended the federal right to abortion in the United States, providers and advocates identified increasing access to emergency contraception as one necessary component of efforts to protect reproductive autonomy.[8] The World Health Organization recommends that emergency contraception be integrated into family planning and other health care services.[9] Use of emergency contraception in the United

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[2] Cohen, C., Conron, K.J., Guardado, R., Serpico, J. (alphabetical author order). (2023). Contraceptive Utilization and Access Among Cisgender Heterosexual and Bisexual California Women. The Center on Reproductive Health, Law, and Policy, UCLA School of Law.

[3] Cohen, C., Conron, K.J., Guardado, R., Serpico, J. (alphabetical author order). (2023). Contraceptive Utilization and Access Among Cisgender Heterosexual and Bisexual California Women. The Center on Reproductive Health, Law, and Policy, UCLA School of Law.

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[6] Barber JS, Ela E, Gatny H, et al. Contraceptive Desert? Black-White Differences in Characteristics of Nearby Pharmacies. *J Racial Ethn Health Disparities*. 2019;6(4):719-732. doi:10.1007/s40615-019-00570-3.

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[9] World Health Organization. Emergency Contraception (November 9, 2021). https://www.who.int/news-room/fact-sheets/detail/

States has steadily increased over the past two decades, with the most recent estimates indicating that 28% of women in the United States ages 15-44 who had ever had sex with a man have ever used emergency contraception.[10] However, barriers to access remain. As recently as 2022, 27% of reproductive age women either did not know that emergency contraceptive pills are available over the counter or had never heard of them at all.[11] Among those who had heard of ECPs, 31% did not know where to purchase them.[12]

In the United States, there are two FDA-approved types of ECPs available to consumers: levonorgestrel (LNG, sold under the brand name "Plan B" among others) and ulipristal acetate (UPA, sold only under the brand name "ella"). LNG emergency contraception (hereinafter "Plan B") first received FDA approval as a prescription-only drug in 1999; it was made available over the counter with age restrictions in 2006 and over the counter for patients of all ages in 2013.[13, 14, 15] UPA emergency contraception (hereinafter "ella"), on the other hand, received FDA approval in 2010 as a prescription-only drug and remains so. Despite not being available over the counter, ella is more effective at preventing pregnancy than Plan B.[16, 17] Ella also remains effective for a longer period of time: while the effectiveness of Plan B drops between 48-72 hours (2-3 days), ella displayed sustained efficacy over 120 hours (5 days) in clinical trials.[18, 19] Moreover, while the effectiveness of both ella and Plan B declines as bodyweight increases—although conclusive data on the effect of weight and BMI on ECP

emergency-contraception.

[10] KKF Women's Health Policy: Emergency Contraception (August 4, 2022) https://www.kff.org/womens-health-policy/fact-sheet/emergency-contraception/.

[11] Frederiksen B, Ranji U, Long M, Diep K, Salganicoff A. Contraception in the United States: A Closer Look at Experiences, Preferences, and Coverage. KFF Women's Health Policy (Nov 3, 2022). https://www.kff.org/report-section/contraception-in-the-united-states-a-closer-look-at-experiences-preferences-and-coverage-executive-summary/.

[12] Frederiksen B, Ranji U, Long M, Diep K, Salganicoff A. Contraception in the United States: A Closer Look at Experiences, Preferences, and Coverage. KFF Women's Health Policy (Nov 3, 2022). https://www.kff.org/report-section/contraception-in-the-united-states-a-closer-look-at-experiences-preferences-and-coverage-executive-summary/.

[13] U.S. Food & Drug Administration Plan B One-Step (1.5 mg levonorgestrel) Information (December 23, 2022) https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/plan-b-one-step-15-mg-levonorgestrel-information.

[14] U.S. Dept. of Health & Human Services Office on Women's Health (December 17, 2020) https://www.womenshealth.gov/30-achievements/19.

[15] Sifferlin A. Timeline: The battle for Plan B. *TIME Magazine*. (June 11, 2013) https://healthland.time.com/2013/06/11/timeline-the-battle-for-plan-b/.

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[17] Practice Bulletin No. 152: Emergency Contraception. *Obstetrics & Gynecology* 126(3):e1-e11, September 2015. DOI: 10.1097/AOG.0000000000001047.

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efficacy is limited and emergency contraception should be offered to patients regardless of weight[20]—ella remains effective at higher weights than Plan B.[21, 22] The 2023 Society for Family Planning Clinical Recommendations place the upper efficacy limit of Plan B at 154.3 lbs. and ella at 187.4 lbs.[23] Therefore, people seeking emergency contraception who weigh in the 155-187 lb. range need access to ella over Plan B. The average American woman weighs 170 lbs.[24] and thus falls in this range. Furthermore, although UPA emergency contraception is available only by prescription, it is no less safe than LNG emergency contraception and has similar side effects that are not more severe.[25, 26, 27] Given these factors, the American College of Obstetricians and Gynecologists recommends prescribing ella over Plan B because it is more effective "at all times up to 5 days after unprotected intercourse and in women of all weights."[28] ACOG also recommends writing prescriptions for advance provision of ECPs to facilitate immediate access, emphasizing advance provision for ella in particular.[29]

Despite its clear advantages, the availability of ella has lagged behind Plan B. At the time of ella's approval, experts speculated that its reach would be limited by the fact that it required a prescription to dispense, while Plan B was already available over the counter.[30] Indeed, use of a prescription for obtaining emergency contraception fell from 31% in 2008 to 18% in 2015.[31] Prior research has found that health care providers lack knowledge about ella and that it is not as commonly available at

[20] Practice Bulletin No. 152: Emergency Contraception. *Obstetrics & Gynecology* 126(3):e1-e11, September 2015. DOI: 10.1097/AOG.0000000000001047.

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[30] Rebecca Kaplan, *The Big Problem with Ella*, Slate Magazine, June 22, 2010 https://slate.com/human-interest/2010/06/the-big-problem-with-ella.html.

[31] Hussain R and Kavanaugh M, Changes in use of emergency contraceptive pills in the United States from 2008–2015, *Contraception: X,* 2021, 3:100065, doi: 10.1016/j.conx.2021.100065. PMID: 34136798; PMCID: PMC8176291.

pharmacies as Plan B.[32, 33, 34]

California is one of eight states that allow pharmacists to prescribe emergency contraception.[35] In 2002, when a prescription was still required for Plan B, California's Senate Bill 1169[36] allowed pharmacists to prescribe emergency contraception pills. The law applied only to Plan B at this time, as ella had not yet entered the market; today, it also applies to ella. While Plan B is available nationally over the counter, California pharmacists can still write prescriptions for it—for instance, if a patient wishes to use insurance to cover the cost of the medication. However, since ella is only available with a prescription, pharmacists are potentially a critical point of access to the medication. This brief draws on data from two sources—a 2022 survey of California pharmacists and the 2020 California Health Interview Survey—to investigate the availability of ella at California community pharmacies and to understand the need for access to ella among people who can get pregnant in California.[37]

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FINDINGS

Among practicing licensed pharmacists surveyed (n=316), most participants identified as women (59.7%) and Asian non-Hispanic (58.5%); the mean participant age was 41 years. Slightly more than half (52.5%) practiced in either the San Francisco Bay Area or Los Angeles County, and over half (55.7%) were employed at chain pharmacies.

Only 21.1% of California pharmacists reported that their pharmacy provides ella without an outside provider's prescription (Table 1). In comparison, Plan B was available without an outside prescription at 78.9% of pharmacies. In addition, significantly more pharmacists reported not knowing whether they provide ella without an outside provider's prescription (14.6%) compared to Plan B (3.9%).

Table 1. Characteristics of practicing licensed pharmacists and community pharmacies in the California Pharmacist Survey (n=316)*, 2022

Participant Characteristics	n	% (95% CI)
Age		
20-34	98	33.1 (27.0, 39.5)
35-44	104	35.1 (29.1, 41.5)
45+	94	31.8 (25.7, 38.2)
Gender		
Cisgender woman	169	59.7 (54.1, 65.8)
Cisgender man	114	40.3 (34.6, 46.3)
Race/ethnicity		
Asian, non-Hispanic	159	58.5 (52.6, 64.6)
White, non-Hispanic	84	30.9 (25.0, 37.0)
Other race/ethnicity	29	10.7 (4.8, 16.8)
Proficient language(s) for service provision		
English	280	94.6 (92.6, 97.2)
Chinese	41	13.9 (10.1, 17.6)
Spanish	37	12.5 (9.1, 16.3)
Vietnamese	23	7.8 (5.1, 10.7)
Other language(s)	37	12.5 (9.1, 16.3)
Characteristics of Participants Pharmacies	**n**	**% (95% CI)**
Pharmacy type		
Chain	176	55.7 (50.3, 61.6)
Independent	131	41.5 (36.1, 47.4)
None of the above	9	2.8 (0.0, 8.8)
Pharmacy region		
Los Angeles County	104	33.3 (27.6, 39.4)
San Francisco Bay Area	60	19.2 (13.5, 25.3)
Other region	148	47.4 (41.7, 53.5)

Characteristics of Participants Pharmacies	n	% (95% CI)
Type of insurance held by majority of clients		
Private insurance	102	34.5 (28.7, 40.7)
Medi-Cal/Medicaid	144	48.6 (42.9, 54.9)
Medicare	43	14.5 (8.8, 20.8)
Uninsured or other insurance	7	2.4 (0.0, 8.6)
Pharmacy provides ulipristal acetate emergency contraception (e.g., ella) without an outside provider's prescription*		
Yes	65	21.1 (15.9, 26.6)
No	198	64.3 (59.1, 69.8)
Not sure/Don't know	45	14.6 (9.4, 20.2)
Pharmacy provides levonorgestrel emergency contraception (e.g., Plan B) without an outside provider's prescription		
Yes	243	78.9 (74.7, 83.5)
No	53	17.2 (13.0, 21.8)
Not sure/Don't know	12	3.9 (0.0, 8.5)
Pharmacy provides self-administered hormonal contraception without an outside provider's prescription		
Yes	144	46.8 (41.2, 52.9)
No	149	48.4 (42.9, 54.5)
Not sure/Don't know	15	4.9 (0.0, 11.0)

*Missing responses (excluded from percentages): age n=20, gender n=33, race and ethnicity n=44, language n=20, pharmacy region n=4, type of insurance n=20, contraceptive provision n=8, levonorgestrel emergency contraceptive provision n=8, ulipristal acetate emergency contraception provision n=8.

Pharmacists who reported that their pharmacy provides hormonal contraception through pharmacist prescription without an outside provider's prescription were over four times as likely to report prescribing ella compared to those at pharmacies that do not prescribe hormonal contraception (36.1% vs. 7.9%; prevalence ratio [PR]: 4.56; 95% CI: 2.59, 8.02). While this indicates that pharmacists who already prescribe in this area may be more likely to be prescribing ella, the proportion of pharmacists who do prescribe ella remains small: only 36.1% of pharmacists who prescribe hormonal contraception also prescribe ella. Meanwhile, 93.1% of them report that Plan B is available at their pharmacy either over the counter or through pharmacist prescription.

Pharmacists who reported serving a primarily Medicare-insured population were about 65% less likely to provide ella than those serving primarily privately insured patients (9.3% vs. 26.5%; PR: 0.35; 95% confidence interval [CI]: 0.13, 0.94) (Table 2). While pharmacists practicing at chain pharmacies were more likely to report providing Plan B than those at independent pharmacies (87.9% vs. 66.9%; PR: 0.76; 95% CI: 0.67, 0.87), the same disparity did not appear for ella (22.4% vs. 20.5%).

Table 2. Provision of emergency contraceptive pills without outside prescription by characteristics of community pharmacies in the California Pharmacist Survey (n=308*), 2022

	Pharmacy provides ulipristal acetate emergency contraception without an outside provider's prescription			Pharmacy provides levonorgestrel emergency contraception without an outside provider's prescription		
	Yes n (%)	No/Don't Know n (%)	PR (95% CI)	Yes n (%)	No/Don't Know n (%)	PR (95% CI)
Overall	65 (21.1%)	243 (78.9%)	-	243 (78.9%)	65 (21.1%)	-
Pharmacy type						
Chain	39 (22.4%)	135 (77.6%)	Reference	153 (87.9%)	21 (12.1%)	Reference
Independent	26 (20.5%)	101 (79.5%)	0.91 (0.59, 1.42)	85 (66.9%)	42 (33.1%)	**0.76 (0.67, 0.87)**
Pharmacy region **						
Los Angeles County	14 (13.7%)	88 (86.3%)	Reference	77 (75.5%)	25 (24.5%)	Reference
San Francisco Bay Area	13 (22.0%)	46 (78.0%)	1.61 (0.81, 3.18)	48 (81.4%)	11 (18.6%)	1.08 (0.91, 1.27)
Orange County	7 (20.6%)	27 (79.4%)	1.50 (0.66, 3.41)	27 (79.4%)	7 (20.6%)	1.05 (0.86, 1.29)
Superior California	9 (36.0%)	16 (64.0%)	2.62 (1.28, 5.36)	24 (96.0%)	1 (4.0%)	1.27 (1.11, 1.46)
Other region	21 (24.4%)	65 (75.6%)	1.78 (0.96, 3.28)	66 (76.7%)	20 (23.3%)	1.02 (0.87, 1.19)
Type of insurance held by majority of clients						
Private insurance	27 (26.5%)	75 (73.5%)	Reference	86 (84.3%)	16 (15.7%)	Reference
Medi-Cal/Medicaid	29 (20.1%)	115 (79.9%)	0.76 (0.48, 1.20)	116 (80.6%)	28 (19.4%)	0.96 (0.85, 1.07)
Medicare	4 (9.3%)	39 (90.7%)	**0.35 (0.13, 0.94)**	28 (65.1%)	15 (34.9%)	**0.77 (0.61, 0.98)**
Uninsured or other insurance	1 (14.3%)	6 (85.7%)	0.54 (0.09, 3.41)	4 (57.1%)	3 (42.9%)	0.68 (0.35, 1.29)
Pharmacy provides self-administered hormonal contraception without an outside provider's prescription						
Yes	52 (36.1%)	92 (63.9%)	**4.56 (2.59, 8.02)**	134 (93.1%)	10 (6.9%)	**1.40 (1.24, 1.57)**
No/Don't Know	13 (7.9%)	151 (92.1%)	Reference	109 (66.5%)	55 (33.5%)	**Reference**

PR: prevalence ratio, CI: confidence interval. *Data subset to 308 participants who answered levonorgestrel emergency contraception and ulipristal acetate emergency contraception provision questions. ** Based on 2020 Census regions, available at: https://census.ca.gov/regions/.

To contextualize these findings and better understand who may be disproportionately disadvantaged by the limited availability of pharmacist-prescribed ella in California pharmacies, we examined demographic data stratified by weight from the 2020 California Health Interview Survey, an annual representative survey of California adults on a range of health-related topics. One quarter (25.1%) of people in California assigned female at birth ages 18-44 weigh between 154-187 lbs.—the weight range at which ella is more effective than Plan B. This group includes 30.2% of Californians assigned female at birth with incomes below the Federal Poverty Line, and is fairly equally distributed across race/ethnicity, including close to one quarter within each racial-ethnic response category. (Table 3). Similarly, this weight group includes approximately one quarter of people assigned female at birth reporting each type of health insurance, including 24.6% of uninsured people assigned female at birth. Starker differences along lines of income, race/ethnicity, insurance status, and access to care emerge above 187 lbs.—the group for which both Plan B and ella may be less effective (Table 3).

Table 3. Characteristics of California women ages 18-44 who participated in the 2020 California Health Interview Survey (n=3,923)

	Participant Weight		
	<155 lbs. % (95% CI)	**155-187 lbs. % (95% CI)**	**>187 lbs. % (95% CI)**
Race/ethnicity			
White, non-Hispanic	57.6 (54.8, 60.3)	25.0 (22.6, 27.6)	17.4 (15.3, 19.7)
Latino/a or Hispanic	45.9 (42.6, 49.2)	28.2 (25.4, 31.1)	25.9 (23.1, 28.9)
Asian, non-Hispanic	78.3 (72.1, 83.4)	17.4 (12.5, 23.6)	4.3 (2.6, 7.0)
Black, non-Hispanic	40.5 (30.2, 51.8)	26.4 (17.7, 37.3)	33.1 (23.2, 44.8)
Any other race alone, or more than one race	68.8 (58.4, 77.6)	15.8 (10.5, 23.1)	15.4 (8.4, 26.4)
Poverty			
<100% federal poverty level	41.8 (35.5, 48.3)	30.2 (24.6, 36.5)	28.0 (22.4, 34.4)
100-199% Federal poverty level	53.2 (48.6, 57.8)	23.2 (18.8, 28.3)	23.5 (19.6, 27.9)
200-299% Federal poverty level	48.6 (42.6, 54.5)	26.3 (21.2, 32.2)	25.1 (20.3, 30.7)
300-399% Federal poverty level	56.3 (49.8, 62.5)	26.0 (20.8, 32.0)	17.7 (13.5, 22.9)
≥400% Federal poverty level	63.1 (60.1, 66.0)	22.8 (20.5, 25.2)	14.1 (12.0, 16.7)
Health insurance type			
Uninsured	56.1 (47.6, 64.2)	24.6 (18.4, 32.1)	19.3 (13.8-26.3)
Medicaid (Medi-Cal)	45.5 (41.0, 50.1)	24.4 (20.5, 28.8)	30.1 (25.8, 34.7)
Employment-based	58.9 (56.2, 61.6)	25.8 (23.6, 28.1)	15.3 (13.6, 17.3)
Other	57.6 (50.1, 64.8)	22.7 (16.2, 30.9)	19.7 (14.3, 26.5)
Experienced delay/did not fill needed prescription in the past 12 months			
Yes	46.9 (40.9, 53.0)	26.5 (21.1, 32.8)	26.6 (21.3, 32.5)
No	55.7 (53.5, 57.8)	24.9 (22.8, 27.1)	19.4 (17.6, 21.4)

DISCUSSION

This study found that only one in five community pharmacists in California works at a pharmacy that provides ella without an outside provider's prescription. Community pharmacists in California offer ella emergency contraception much less frequently than they do Plan B. These findings are in line with past studies that have found disparities in availability between ella and Plan B both in California[38] and across the United States.[39, 40, 41, 42, 43] Furthermore, a significantly larger portion of pharmacists in our sample did not know whether their pharmacy offered ella, compared to Plan B. This finding is in line with past research finding that pharmacists lacked familiarity with ella compared to Plan B.[44] The overall lack of provision combined with lack of knowledge indicates that California pharmacists may need further education on ella emergency contraception. The issue is not limited to pharmacists—physicians and advanced practice clinicians have also been found to be less familiar with ella than Plan B (in a sample of practitioners from various specialties, 95% had heard of Plan B while only 52% had heard of ella).[45]

Comparing the availability of Plan B and ella is complicated by the fact that not all of the pharmacists in our sample who reported providing Plan B without an outside provider's prescription did so by prescribing it themselves. Because Plan B is also offered behind the counter and over the counter, pharmacists are not required to exercise their prescription power when providing it, as they are with ella. For this reason, we compared provision of ella to hormonal contraception. Our findings indicate that prescribing hormonal contraception is associated with prescribing ella. A potential explanation for this association is that pharmacists who are already prescribing hormonal contraception may have increased knowledge or interest in providing reproductive health care and exercising their prescription power to do so. However, pharmacist-prescribed provision of ella still lags far behind pharmacist-

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[39] Bullock H, Steele S, Kurata N, Tschann M, Elia J, Kaneshiro B, Salcedo J. Pharmacy access to ulipristal acetate in Hawaii: is a prescription enough? *Contraception*. 2016 May;93(5):452-4. doi: 10.1016/j.contraception.2015.12.003. Epub 2015 Dec 12. PMID: 26689477; PMCID: PMC5576956.

[40] Brant A, White K, St Marie P. Pharmacy availability of ulipristal acetate emergency contraception: an audit study. *Contraception.* 2014;90(3):338–9.

[41] Stone RH, Gross S, Reardon B, Young HN. Emergency Contraception Access and Counseling in Metropolitan and Nonmetropolitan Pharmacies in Georgia. *Journal of Pharmacy Practice*. 2023;36(3):523-531. doi:10.1177/08971900211052821

[42] Shigesato M, Elia J, Tschann M, Bullock H, Hurwitz E, Wu YY, Salcedo J. Pharmacy access to Ulipristal acetate in major cities throughout the United States. *Contraception*. 2018 Mar;97(3):264-269. doi: 10.1016/j.contraception.2017.10.009. Epub 2017 Oct 31. PMID: 29097224; PMCID: PMC6467254.

[43] American Society for Emergency Contraception. *2022 Emergency Contraception Access Report*. (February 2023).

[44] Kaur G, Fontanilla T, Bullock H, Tschann M. "The Difference between Plan b and ella®? They›re Basically the Same Thing»: Results from a Mystery Client Study. *Pharmacy (Basel)*. 2020;8(2):77. Published 2020 May 1. doi:10.3390/pharmacy8020077.

[45] Batur P, Cleland K, McNamara M, Wu J, Pickle S; EC Survey Group. Emergency contraception: A multispecialty survey of clinician knowledge and practices. *Contraception*. 2016 Feb;93(2):145-52. doi: 10.1016/j.contraception.2015.09.003. Epub 2015 Sep 10. PMID: 26363429; PMCID: PMC4703545.

prescribed hormonal contraception: only 36% of pharmacists in our sample who reported prescribing hormonal contraception did the same for ella emergency contraception. Given their already-demonstrated willingness to prescribe in this area, this population represents a potential opportunity for expansion of ella availability in California pharmacies. Statewide efforts to increase pharmacist prescription of hormonal contraception could therefore realistically include attention to prescribing ella as well.

Given that Plan B is already so widely available, why does the lack of availability of ella matter? Ella is the more effective method and is effective for a longer post-coital window. For those reasons alone, equitable access should be sought between Plan B and ella to ensure that patients have the full range of options, including the most effective options. The fact that ella remains effective for two days longer than Plan B also provides advantages to patients who may experience delays in seeking out emergency contraception, such as minors and survivors of sexual assault.

Ella is also effective at higher weights than Plan B. While a clear consensus has not yet emerged on the exact weight at which effectiveness for Plan B and ella begins to decline, this brief follows the more conservative recommendations of the Society for Family Planning, which places the respective efficacy limits at 70 kg (approximately 154 lbs.) and 85 kg (approximately 187 lbs.). Therefore, women and pregnancy-capable transgender and nonbinary people weighing in the 155-187 lb. range need access to ella over Plan B, and our data indicates that they may experience barriers to accessing ella in California. Those at higher weights may face compounding marginalizations such as racism, economic insecurity, and precarity in their access to health care. When faced with the time-sensitive need for emergency contraception, they may not have access to the form of emergency contraceptive pills most likely to be effective for them. Of note, Californians assigned female at birth weighing more than 187 lbs. were more likely to be people of color, low income, Medicaid-insured, and to have experienced delays accessing a prescription. These women may not be served by either Plan B or ella (although the data on weight/BMI and ECP effectiveness is not yet conclusive, and clinical recommendations do not exclude women over a certain weight or BMI threshold from ECP eligibility). Other than ECPs, the only other emergency contraception option is the Intrauterine device (IUD), a categorically different method which should not be considered a universal substitute for ECPs for people at higher weights. There is a critical need for more robust data on the weight effectiveness thresholds of both Plan B and ella to determine with a greater level of certainty who might be disproportionately impacted by the landscape of availability of ECPs.

RESEARCH AND POLICY RECOMMENDATIONS

Investigate and address barriers to California pharmacist prescribing of ella. To realize the potential benefits of pharmacist prescribing of ECPs in California, pharmacists must be willing and able to prescribe ella. Further research is needed to identify reasons that pharmacies are currently not offering ella without an outside provider's prescription. Potential policy solutions might include educating pharmacists on the differences between ella and Plan B ECPs, ensuring that pharmacists are reimbursed for prescribing ella, or monitoring compliance with Affordable Care Act requirements that emergency contraception be covered by most insurance plans.

Target pharmacists who prescribe hormonal contraception for initiatives aimed at increasing pharmacy access to ella. Given that pharmacists who already prescribe hormonal contraception are more likely to also prescribe ella, initial efforts at further expanding access to ella could begin with this population. Furthermore, efforts to increase pharmacist prescribing of hormonal contraception could also include education on ella.

Make ella available without a prescription. Ella has a demonstrated safety record that is comparable to Plan B, and it can be used safely without a prescription. FDA should follow the lead of the European Medicines Agency, which in 2014 recommended that European Union countries change the classification of UPA ECPs from prescription to non-prescription status.[46] By 2015, most European Union countries had followed the recommendation and made UPA ECPs available without a prescription.[47] Allowing ella to be sold over the counter in the US would pave the way for it to be equally available at pharmacies, particularly when pharmacists are not exercising their prescription power to furnish emergency contraception.

However, care should be taken that moving ella to over-the-counter status does not jeopardize insurance coverage for the drug. Policymakers should follow the lead of the Affordability is Access Act, re-introduced into the Senate in May 2023.[48] The bill would require insurers to pay for over the counter hormonal contraception once it receives FDA approval. Similar guarantees must be made in the emergency contraception context in the interest of equity of access.

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[46] Press Release: EMA recommends availability of ellaOne emergency contraceptive without prescription. European Medicines Agency. (November 21, 2014) https://www.ema.europa.eu/en/news/ema-recommends-availability-ellaone-emergency-contraceptive-without-prescription.

[47] Italia S, Brand H. Status of Emergency Contraceptives in Europe One Year after the European Medicines Agency's Recommendation to Switch Ulipristal Acetate to Non-Prescription Status. *Public Health Genomics*. 2016;19(4):203-210. doi:10.1159/000444686

[48] Press Conference: Murray, Hirono, Cortez Masto Rally for Over-The-Counter Birth Control, Reintroduce Affordability is Access Act. (May 18, 2023) https://www.murray.senate.gov/murray-hirono-cortez-masto-rally-for-over-the-counter-birth-control-reintroduce-affordability-is-access-act/.

APPENDIX

STUDY METHODS

Data for this brief were drawn from the California Pharmacist Survey, a cross-sectional, online survey of California pharmacists and pharmacy students conducted between October 11 and December 20, 2022. The California Pharmacist Survey was developed to understand the attitudes, knowledge, and preferences of pharmacists regarding the provision of sexual and reproductive health services in pharmacies, including contraception and medication abortion. The survey also gathered information about the implementation of policies enabling pharmacist-prescribed hormonal contraception at pharmacies as reported by pharmacist employees. The study was approved by the Office of the Human Research Protection Program Institutional Review Board at UCLA with partner organizations holding reliance agreements.

Study Population and Recruitment

Eligible participants in the California Pharmacist Survey were: 1) ≥ 18 years of age, 2) licensed pharmacists or pharmacy students, 3) currently residing in the state of California, and 4) willing to provide informed consent. Participants were excluded from the survey if they did not meet the inclusion criteria or were identified via security and quality control measures as being a duplicate or bot. A multi-stage recruitment plan included both online and in-person recruitment. In the first phase, participants were recruited through the California Society of Health-System Pharmacists and California Pharmacists Association membership email listservs and newsletters. Information about the study was also distributed through flyers and presentations at two conferences: the annual meetings of the American College of Clinical Pharmacy and the California Society of Health-System Pharmacists. The second phase included participant recruitment through the social media channels (i.e., Facebook, LinkedIn, and Twitter) of partner organizations and a focused recruitment effort to include diverse representation of California pharmacists. The survey was also promoted to professional groups on social media representing Black, Indigenous, and other People of Color pharmacists and pharmacists outside of major metropolitan areas in California (e.g., California's rural Central Valley).

Data Collection

The self-administered survey was implemented via Qualtrics online survey software. Survey modules included: demographic information; professional information (years of experience, training, whether currently practicing); pharmacy information; and knowledge, attitudes, and implementation of PrEP, PEP, hormonal contraception, emergency contraception, and medication abortion. Upon completing the survey, participants had the option to enter their email address to receive a $20 Amazon gift card and/or enter weekly ($250) or grand prize ($500) raffles. Only participants verified as valid were eligible for gift cards and raffle prizes.

Data Analysis

Descriptive statistics were presented for selected survey outcomes. Percentages were calculated excluding missing or "not applicable" responses from the denominators. Prevalence ratios were estimated via log-binomial regression. When appropriate, results were limited to relevant subgroups (e.g., pharmacists working in community pharmacies). All analyses were conducted in R statistical computing software.

In addition to 2022 data from the California Pharmacist Survey, 2020 California Health Interview Survey (CHIS) data were analyzed for this report. CHIS is a health survey managed by the UCLA Center for Health Policy Research. CHIS data are collected via an annual survey from a representative household sample of about 20,000 adults ages 18 and up on a range of health-related topics including reproductive health and birth control utilization. We limited our analytic sample to women ages 18-44. Respondents were classified by their reported weight into one of three weight groups: under 155 lbs., 155-187 lbs., and over 187 lbs. We performed descriptive analyses using design-based F-tests (Rao- Scott Chi-square tests) of differences in proportions to assess whether sociodemographic and health characteristics varied across weight groups at an alpha of 0.05. Confidence intervals (95% CI) were included to communicate the degree of uncertainty around an estimate due to sampling error. Non-overlapping confidence intervals were deemed indicative of statistically significant differences in two proportions at an alpha of 0.05. All analyses were conducted using Stata v17.1 and weighted using person-level weights provided by the UCLA Center for Health Policy Research. All sample sizes (n) are unweighted.

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