Reforming the Practice of Pharmacy: Observations from Idaho

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ABSTRACT

Owing to a series of incremental legislative and regulatory changes in recent years, the practice of pharmacy in Idaho, particularly with respect to pharmacists' prescribing authority, has expanded far beyond what is permitted in any other state. This paper reviews the recent history of Idaho's reforms, surveys academic literature looking at similar reforms that have occurred in other jurisdictions, and addresses concerns raised by some opponents of Idaho's reforms. All told, the results of liberalization have been almost entirely positive in Idaho, as demonstrated by a clear increase in access for patients, a lack of any obvious increases in risk, and an improved business climate. Consequently, Idaho's reforms offer a roadmap for states interested in pursuing a model of "permissionless innovation" for pharmacists.

JEL codes: H75, I18, I11, K23

Keywords: pharmacists, scope of practice, prescribing authority, regulation, Idaho, permissionless innovation

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In recent years, a quiet revolution has transformed the practice of pharmacy in Idaho. This revolution reached its apex when, in 2019, Idaho House Bill (H.B.) 182 was approved unanimously by the Idaho State Legislature.[1] The new law was the culmination of a series of changes to the practice of pharmacy in the state, reforms that had slowly been gaining momentum over the previous decade. Whereas past reforms had allowed pharmacists to take on new responsibilities one at a time, H.B. 182 constituted an altogether new approach in that, for the first time, it extended pharmacists' prescribing authority to any medication that fit within certain broad, established categories set by the state legislature and the state board of pharmacy. This law has almost certainly made Idaho the least restrictive US state with respect to pharmacists' prescribing authority.

Idaho's approach is a dramatic departure from the approach taken in other states. Most states take a precautionary approach in that pharmacists' ability to prescribe a certain medication or medical product is banned by default, and exceptions are considered on a case-by-case basis. Idaho's approach, by contrast, is best described as a "permissionless innovation" approach.[2] Under the usual approach, the burden of proof falls on pharmacists and patients to explain why a certain activity is necessary; after the passage of H.B. 182, many activities in Idaho are now allowed by default, enabling pharmacists to use their extensive knowledge and training with far fewer restrictions, unless a sound reason is identified as to why a particular activity would not be in the public interest.

This paper reviews the innovative reforms that have taken place in Idaho over the past decade. Section I begins by providing an overview of Idaho's reforms, which are truly remarkable for two reasons: First, the reforms expanded the scope of the practice of pharmacy far beyond what is permitted in any other state, at

1. An Act Relating to Pharmacists, H.B. 182, 65th Leg., 1st Sess. (Idaho 2019).
2. Adam Thierer, *Permissionless Innovation: The Continuing Case for Comprehensive Technological Freedom*, rev. ed. (Arlington, VA: Mercatus Center at George Mason University, 2016).

least with regard to prescribing authority. Second, the results have been unambiguously positive to date, as demonstrated by a clear increase in access for patients, a lack of any obvious increases in risk, and an improved business environment. Section II provides evidence from other, more modest reforms that have taken place in other jurisdictions—most notably in several midwestern US states, the United Kingdom, and Canada—and reviews lessons learned from changes in federal medical lab laws over the past few decades. Section III discusses some of the objections raised by opponents of Idaho's reforms. Opposition comes primarily from groups, such as medical associations, that represent physicians and others who could stand to lose financially if pharmacists are allowed to compete with them and practice to the full extent of their medical training. Such objections should not be surprising, given that the current regulatory system privileges certain groups, and they can be expected to fight to maintain their privilege. Section IV concludes that, despite such opposition, Idaho's package of reforms seems to represent a clear win for pharmacists and patients. Therefore, these reforms can serve as a model for other states.

I. OVERVIEW OF IDAHO'S REFORMS

The story of Idaho's wave of pharmacy reforms begins in 2011, when the state legislature acted to give pharmacists authority to prescribe fluoride supplements for those who suffered from a deficiency of fluoride in their water, as well as agents for active immunizations for susceptible individuals ages 12 and over.[3] Although little action was taken following this particular pharmacy reform until 2015, the 2011 H.B. 218 set the stage for bigger reforms to come. For instance, in 2015, in response to the growing opioid crisis, pharmacists received authority to prescribe opioid antagonists such as Narcan.[4] In 2016, the age at which some immunizations could be prescribed was lowered to six years,[5] and epinephrine auto-injectors (e.g., EpiPens) were added to the list of medicines pharmacists could prescribe.[6] In early 2017, tuberculosis tests and tobacco cessation products were also added to this list.[7]

During the 2011–2017 period, the Idaho State Legislature took a piecemeal approach to expanding pharmacists' prescribing authority. However, the

3. An Act Relating to Pharmacists, H.B. 218, 61st Leg., 1st Sess. (Idaho 2011).
4. An Act Relating to Pharmacy, H.B. 108, 63rd Leg., 1st Sess. (Idaho 2015).
5. An Act Relating to the Practice of Pharmacy, S.B. 1294, 63rd Leg., 2nd Sess. (Idaho 2016).
6. An Act Relating to Epinephrine Auto-Injectors, S.B. 1322, 63rd Leg., 2nd Sess. (Idaho 2016).
7. An Act Relating to Pharmacists, H.B. 3, 64th Leg., 1st Sess. (Idaho 2017); An Act Relating to Pharmacists, H.B. 4, 64th Leg., 1st Sess. (Idaho 2017).

challenge of a piecemeal approach is that each new medication must be individually added to the list of medicines that pharmacists can prescribe. This approach slowed progress in Idaho and, worse, gave interest groups a clear target to fight. In other words, the introduction of legislation that singled out specific medicines created an opportunity for interest groups to push back, which meant that every reform turned into a bruising battle with opposition groups. Every year, interest groups such as the Idaho Medical Association and the American Medical Association, individual medical professionals, insurance companies, and even other state agencies would show up at the legislature to oppose efforts to expand pharmacists' prescribing authority.[8]

This dynamic began to change in 2017 after the passage of H.B. 191. Rather than singling out specific medicines or devices, H.B. 191 established general parameters that would be used to determine whether a pharmacist could prescribe a particular medication or device. Specifically, the legislation gave the Idaho Board of Pharmacy power to authorize pharmacists to prescribe medications for medical conditions that (a) do not require a new diagnosis, (b) are minor and self-limiting, (c) have a low-risk test to guide in identification of the condition,[9] or (d) are an immediate danger to the patient such that an immediate prescription is needed.[10] The operative word in this list is "or," as any situation meeting any one of these rather general criteria was grounds to grant a pharmacist certain prescribing authority. Any of these categories in and of itself would

8. See, for example, opposition to 2016 legislation granting pharmacists authority to prescribe active immunizations to those age six and older: Idaho Senate Health and Welfare Committee, *Minutes*, February 17, 2016, https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2016/standingcommittees/160217_sh&w_0300PM-Minutes.pdf. See opposition to 2017 legislation to enable pharmacists to prescribe tobacco cessation products: Idaho House Health and Welfare Committee, *Minutes*, January 25, 2017, 2, https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2017/standingcommittees/170125_hhea_0900AM-Minutes.pdf. See opposition by insurers to 2015 legislation to enable pharmacists to prescribe opioid antagonists: Idaho House Health and Welfare Committee, *Minutes*, February 18, 2015, 4–5, https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2015/standingcommittees/150218_hhea_0900AM-Minutes.pdf. In addition, see examples of the letters from industry in opposition to some of Idaho's reforms since 2017, as well as meeting notes from hearings surrounding legislation: Letter from James L. Madara, American Medical Association, to Idaho Governor Brad Little, March 21, 2019, https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2019-3-21-Letter-in-opposition-to-ID-HB-182-FINAL.pdf; Idaho Senate Health and Welfare Committee, *Minutes*, March 7, 2017, 3–4, https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2017/standingcommittees/170307_sh&w_0300PM-Minutes.pdf; and Letter from Anne Lawler, on behalf of Idaho Board of Medicine, to Alex Adams, Idaho State Board of Pharmacy, October 24, 2017, https://bom.idaho.gov/BOMPortal/BOM/Laws_Rules/board_of_pharmacy_letter_2.pdf.
9. The test must also be waived under the Clinical Laboratory Improvement Amendments, which are discussed in more detail in the next section.
10. An Act Relating to Pharmacy, H.B. 191, 64th Leg., 1st Sess. (Idaho 2017).

considerably expand the scope of legal activities that pharmacists could engage in. Altogether, however, these categories create a vast new domain within which pharmacists can legally prescribe.

With the nearly unanimous passage of H.B. 191 and its signature by the governor,[11] pharmacists and medical providers no longer had to go to the legislature—which meets for only three to four months in the winter[12]—to give pharmacists the authority to prescribe medications that meet the pressing needs of the community. H.B. 191 meant Idaho's state board could improve policy year round without the costly and time-consuming efforts of lobbyists and legislators that are associated with moving unique legislation to address every issue.

With its newfound authority, the Idaho Board of Pharmacy quickly began working to identify the medications pharmacists might be able to prescribe or administer and to craft rules governing those activities. For example, the board wrote new rules to give pharmacists authority to prescribe medications to combat lice, cold sores, motion sickness, uncomplicated urinary tract infections, and influenza (flu), as well as medications for travel to foreign countries, among other items.[13] Each medication permitted by the board had to fit within the overarching framework of H.B. 191 (i.e., not require a diagnosis, be related to minor conditions and be self-limiting, be diagnosed with a low-risk test, or relate to an emergency). The new board rules required pharmacists and medical providers to use a collaborative approach, such that a pharmacist "must recognize the limits of the pharmacist's own knowledge and experience and consult with and refer to other health care professionals as appropriate."[14]

Once the rules were written, they had to be approved by the Idaho State Legislature because the legislature has the authority to review administrative rules promulgated by Idaho state agencies.[15] In 2018, the new rules implementing H.B. 191 went before the House and Senate Health and Welfare Committees in the state legislature for approval. There was unanimous committee member support for the agency rules.[16] In fact, shortly after approving these new administrative

11. H.B. 191.
12. Idaho State Legislature, *Sine Die Report: A Summation of the 2019 Legislative Session*, 2019, 6.
13. Idaho Board of Pharmacy, "2018 Rule Changes," Docket Number 27-0104-1701, § 21, § 23, and § 25, https://bop.idaho.gov/wp-content/uploads/sites/99/code_rules/2018_RuleChanges.pdf.
14. Idaho Board of Pharmacy, "2018 Rule Changes," Docket Number 27-0104-1701, § 20.04.
15. Idaho Code Ann. § 67-5291 and § 67-5292 (2019).
16. Idaho House Health and Welfare Committee, *Minutes*, January 10, 2018, 2, https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2018/standingcommittees/180110_hhea_0900AM-Minutes.pdf; Idaho Senate Health and Welfare Committee, *Minutes*, January 10, 2018, 6, https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2018/standingcommittees/180110_sh&w_0300PM-Minutes.pdf.

rules, the legislature took up H.B. 339, which allowed pharmacists the authority to substitute pharmaceutical equivalents for medications if the original licensed prescriber permitted it.[17] For example, if a physician prescribed a medication but also included permission to substitute, the medication the pharmacist dispensed could be a different but therapeutically equivalent drug. This bill also passed unanimously.[18]

Around the same time, H.B. 351 from the 2018 legislative session went beyond just pharmacists' prescribing authority and implemented a major overhaul for the entire practice of pharmacy in Idaho.[19] Key provisions of H.B. 351 simplified procedures for reciprocal licensure (i.e., accepting out-of-state licenses), eliminated registration requirements for veterinary drug outlets, allowed certain retail facilities to sell small amounts of over-the-counter medications (e.g., a gas station that sells packets of ibuprofen), allowed for transmission of prescription drug orders using digital images of written prescriptions, and eliminated certain geographical restrictions.

By eliminating geographical restrictions, H.B. 351 built on several rule changes made by the Idaho Board of Pharmacy in 2017 that allowed for significantly expanded practice of telepharmacy in the state.[20] This meant pharmacies could dispense medications without a licensed pharmacist on the premises, which had been required earlier. Such changes allowed pharmacy technicians and other employees to run day-to-day pharmacy operations with a licensed pharmacist on call; the pharmacist might come in one or two days a week or otherwise be available to talk to patients over the telephone or via a video conferencing platform such as Zoom or Skype. This change has the potential to dramatically reduce costs for small pharmacies because the cost of having a full-time licensed pharmacist on staff can be considerable.

After the 2018 legislative session ended, the Idaho Board of Pharmacy issued rules to further extend pharmacists' prescribing authority to include medications for mild acne, mild coughs, and allergic rhinitis.[21] In 2019, however, the process came full circle. As the legislative session began, reforms made in

17. An Act Relating to Pharmacy, H.B. 339, 64th Leg., 2nd Sess. (Idaho 2018).
18. H.B. 339.
19. An Act Relating to Pharmacy, H.B. 351, 64th Leg., 2nd Sess. (Idaho 2018).
20. See Idaho Admin. Code, Docket No. 27-0101-1602. The legislature expanded the practice of telepharmacy when it passed the Idaho Telehealth Access Act in 2015, which allowed medical providers, including pharmacists, to provide telehealth services to patients in Idaho. See An Act Relating to Telehealth Services, H.B. 189, 63rd Leg., 1st Sess. (Idaho 2015).
21. Idaho Admin. Code, Docket No. 27-0104-1802, at 403, https://bop.idaho.gov/wp-content/uploads/sites/99/2019/07/2019_Rule_Changes.pdf.

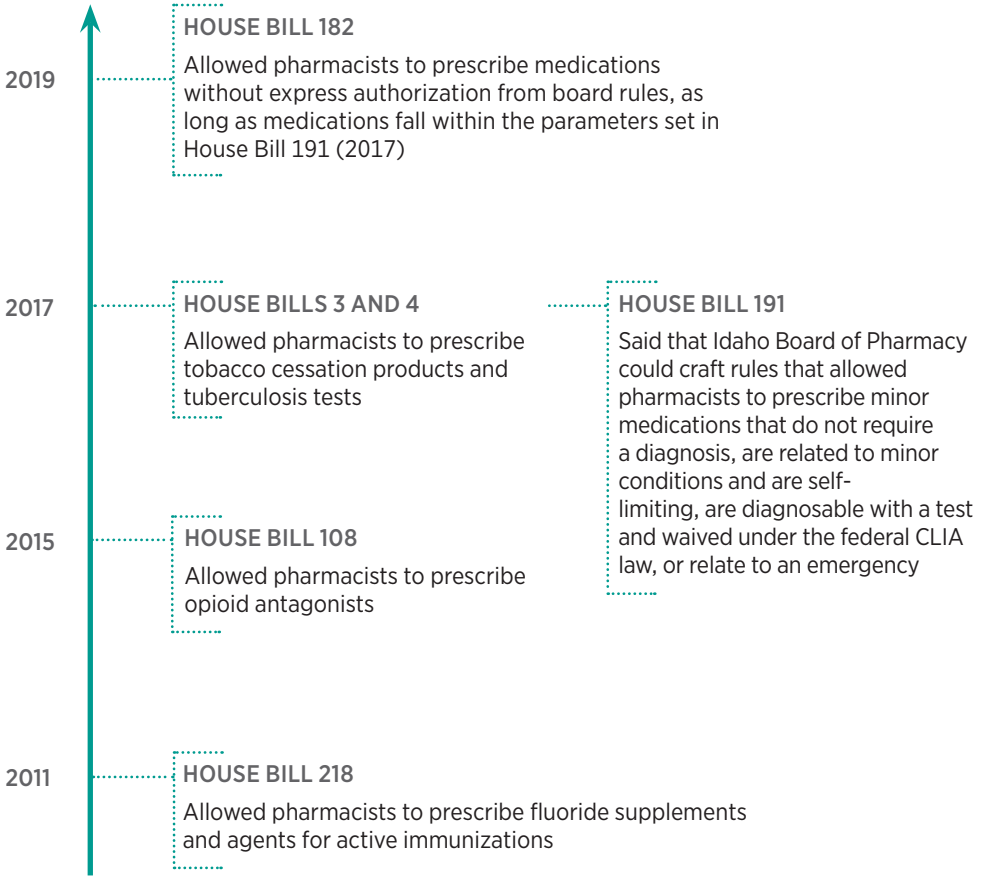
previous years prompted noticeable changes in communities across the state. For example, a new pharmacy opened in the 2,000-person town of Victor, Idaho, which had not had a pharmacy for several decades.[22] Changes to telepharmacy laws were a key factor in the new pharmacy's viability; the pharmacy hired a licensed pharmacist, who lived in a nearby town and who could be reached electronically or by telephone for counseling and consultations.[23] Additionally, CVS Health announced it would begin construction of a new facility to process mail orders in Idaho. The facility was expected to bring up to 150 jobs to Boise, as a direct result of the newly liberalized pharmacy laws.[24]

Buoyed by the news from around the state, Idaho's House Health and Welfare Committee approved the rules adopted by the Idaho Board of Pharmacy and took on a further overhaul of pharmacy laws and regulations.[25] In 2019, H.B. 10 eliminated much of the obsolete language that remained in statutes governing the profession, and it established a new multistate pharmaceutical licensure agreement.[26] The agreement operates similarly to a nurse licensure compact that 34 states have adopted.[27] The agreement also allows for recognition of a pharmacist license issued by another state, as long as that state also recognizes a license issued by Idaho.

Finally, in 2019, H.B. 182 was approved unanimously by the Idaho State Legislature.[28] This law made further changes to pharmacists' prescribing authority. Rather than requiring express authorization for a specific medication by the state pharmacy board, H.B. 182 allowed pharmacists to prescribe any medication that fit within the standards that had been established by the legislature and the Idaho Board of Pharmacy in previous years, unless expressly prohibited by the pharmacy board. In other words, the burden of proof was reversed, and a framework of permissionless innovation was established. Whereas previously, the prescription of any medication or device was disallowed automatically unless authorized by the Idaho Board of Pharmacy or the state legislature, now the activity in question would be allowed unless expressly prohibited (figure 1—see also table A1 in the appendix for a comprehensive list of Idaho's pharmacy reforms). This

22. Julia Tellman, "Telepharmacy Key to New Victor Drug Store," *Teton Valley News*, July 26, 2018.
23. Tellman, "Telepharmacy Key to New Victor Drug Store."
24. Melissa Davlin, "Board of Pharmacy Changes Get Bipartisan Praise, and Interest from Private Business," *Idaho Reports,* January 14, 2019.
25. Idaho House Health and Welfare Committee, *Minutes,* January 14, 2019, https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2019/standingcommittees/190114_hhea_0900AM-Minutes.pdf.
26. An Act Relating to Pharmacy, H.B. 10, 65th Leg., 1st Sess. (Idaho 2019).
27. National Council of State Boards of Nursing, "Nurse Licensure Compact (NLC)," accessed February 26, 2020, https://www.ncsbn.org/nurse-licensure-compact.htm.
28. H.B. 182.

FIGURE 1. TIMELINE OF SELECT IDAHO PHARMACY REFORMS



less restrictive approach has ushered in a dramatic change in mindset for pharmacy regulation in Idaho, and it will almost certainly open the door to more collaboration between pharmacists, physicians, and patients going forward.

II. OTHER EVIDENCE

The success of Idaho's reforms should not be a surprise given that previous research has also found beneficial outcomes from pharmacy liberalization efforts. Such efforts include, for example, those undertaken at the federal level in the United States, in other US states besides Idaho, and in other countries. One area that has received considerable attention in the academic literature is the

passage of the Clinical Laboratory Improvement Amendments (CLIA) of 1988,[29] which allowed pharmacies and other entities in the United States to conduct low-risk laboratory testing. The CLIA program created a process whereby federal waivers are issued to allow certain facilities to administer low-risk, routine medical tests. "Waived" tests include those relevant to conditions such as strep throat, flu, and human immunodeficiency virus (HIV), among many others.[30]

The number of CLIA-waived testing labs has gradually increased over time.[31] More sites make it easier and quicker for patients to receive necessary health information and to address conditions than it would be if patients waited to see a doctor. Research indicates that "pharmacies are currently the fourth highest-ranking facility of CLIA-waived laboratories with 10,838 locations,"[32] with supermarket-based facilities making up 43 percent of these accessible pharmacies. Still, pharmacies across the United States do not take advantage of the CLIA-waiver process consistently. From state to state, the percentage of pharmacies holding a CLIA waiver ranges from 0 percent to 60 percent.[33]

Michael Klepser and his coauthors suggest that a key explanation for such variation is differences in state-to-state regulation.[34] Specifically, they point out that certain states impose different state-specific legal barriers that prevent pharmacies from obtaining CLIA waivers. Such barriers can include state-specific regulation for testing procedures, licensure of personnel conducting tests or overseeing the lab, phlebotomy requirements, and waste disposal requirements.[35] Possibly as a result of such barriers, Nevada, New York, and Rhode Island have some of the lowest percentages of CLIA-waived pharmacies in the United States, at 0 percent, 0.40 percent, and 0.53 percent, respectively, as of 2015.[36] In many states,

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29. Clinical Laboratory Improvement Amendments of 1988, Pub. L. No. 100-578, 102 Stat. 2903 (1988).
30. US Food and Drug Administration, "CLIA—Clinical Laboratory Improvement Amendments—Currently Waived Analytes," last updated March 23, 2020, https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm.
31. American Association for Clinical Chemistry, "Modernization of CLIA: Certificate of Waiver Testing Sites," October 30, 2018, https://www.aacc.org/health-and-science-policy/advocacy/position-statements/2018/modernization-of-clia-certificate-of-waiver-testing-sites.
32. Michael Klepser et al., "U.S. Community Pharmacies as CLIA-Waived Facilities: Prevalence, Dispersion, and Impact on Patient Access to Testing," *Research in Social and Administrative Pharmacy* 12, no. 4 (2015): 614.
33. Klepser et al., "U.S. Community Pharmacies," 616.
34. Klepser et al., 616.
35. Devery Howerton et al., "Good Laboratory Practices for Waived Testing Sites," Centers for Disease Control and Prevention, last reviewed October 26, 2005, https://www.cdc.gov/Mmwr/preview/mmwrhtml/rr5413a1.htm.
36. See Klepser et al., "U.S. Community Pharmacies," 617.

people end up waiting days or even weeks for appointments with a primary care physician,[37] including for simple lab tests or flu screenings. Providing more CLIA-waived low-risk medical tests would have the potential to significantly reduce patient wait times. Furthermore, previous studies have shown that pharmacists are able to incorporate routine testing into their current work hours to accommodate the high demand for non-life-threatening healthcare needs.[38]

A number of studies by professionals in the medical and pharmacy fields find that pharmacists' assistance in addressing immediate, non-life-threatening healthcare needs is effective. For example, Donald and Michael Klepser and their coauthors examine data from 55 pharmacies across Michigan, Minnesota, and Nebraska.[39] They find that pharmacists, when involved in a collaborative practice agreement with a physician, are fully capable of performing a variety of functions that sometimes fall outside their normal legal authority.[40] These functions include timely and low-cost medical testing and treatment for such illnesses as strep throat and flu,[41] findings consistent with previous research showing that pharmacists can cost-effectively treat strep throat.[42] In the case of diabetes, research has found that granting pharmacists the ability to prescribe statins could remove a gap in care of patients ages 40–75 with diabetes, as statins have been found to reduce cardiovascular disease and mortality in individuals with diabetes.[43] Indeed, in 2018, Idaho became the first state to allow pharmacists to prescribe statins to persons in that age category who were previously diagnosed

37. Merritt Hawkins Team, "2017 Survey of Physician Appointment Wait Times," September 22, 2017, https://www.merritthawkins.com/news-and-insights/thought-leadership/survey/survey-of-physician-appointment-wait-times/.
38. Edward J. Timmons and Conor S. Norris, "CLIA Waiver Pharmacy Growth: How Does Broadening Scope of Practice Affect the Pharmacist Labor Market?" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, October 2016).
39. Donald G. Klepser et al., "Community Pharmacist-Physician Collaborative Streptococcal Pharyngitis Management Program," *Journal of the American Pharmacists Association* 56, no. 3 (2016); Michael Klepser et al., "Effectiveness of a Pharmacist-Physician Collaborative Program to Manage Influenza-Like Illness," *Journal of the American Pharmacists Association* 56, no. 1 (2016).
40. Note that Idaho's core reforms, which are the focus of this paper, do not require such an agreement to be in place.
41. Donald Klepser et al., "Community Pharmacist-Physician Collaborative Streptococcal Pharyngitis Management Program"; Michael Klepser et al., "Effectiveness of a Pharmacist-Physician Collaborative Program to Manage Influenza-Like Illness."
42. Donald G. Klepser et al., "Cost-Effectiveness of Pharmacist-Provided Treatment of Adult Pharyngitis," *American Journal of Managed Care* 18, no. 4 (2012).
43. See Thomas Vanderholm et al., "An Innovative Approach to Improving the Proposed CMS Star Rating 'Statin Use in Persons with Diabetes,'" *Journal of Managed Care and Specialty Pharmacy* 24, no. 11 (2018); and Yashashwi Pokharel et al., "Practice-Level Variation in Statin Use among Patients with Diabetes: Insights from the PINNACLE Registry," *Journal of the American College of Cardiology* 68, no. 12 (2016).

with diabetes.[44] The new rules could help close the gap in the care of patients ages 40–75 while maintaining an appropriate regulatory framework to ensure patients' safety.

As in Idaho, laws in Arkansas, Kentucky, and Washington State also allow pharmacists to substitute therapeutic equivalents for drugs of a similar class.[45] With appropriate precautions in place, such as original prescriber opt-in programs and the requirement that pharmacists inform original prescribers in a timely manner to ensure the accuracy of patients' medical records and history of care, these measures have been shown to save time, enhance patient care, and reduce healthcare costs.[46]

Similar initiatives aimed at expanding the scope of pharmacy were introduced in England in 2014–2015.[47] These initiatives formed part of an effort to reduce unnecessary antibiotic use. In 35 community pharmacies in two localities in the country, pharmacists were allowed to perform strep throat tests after assessing a patient's health on the basis of a four-criterion test meant to determine if further bacterial testing would be beneficial. In the case of a positive strep throat test result, the patient is offered antibiotic treatment. The authors of one study conclude, "It is feasible to deliver a community-pharmacy-based screening and treatment service using point-of-care testing. This type of service has the potential to support the antimicrobial resistance agenda by reducing unnecessary antibiotic use and inappropriate antibiotic consumption."[48]

Canada is another potential model. Changes in Canadian pharmacy regulation over the past 15 years have focused on increasing the scope of pharmacists' work to include more patient care and the authority to prescribe medication in certain circumstances. Alberta was the first province in Canada to expand the scope of pharmacy practice in this recent wave, with changes passed by law in 2006 and implemented in 2007.[49] Changes fell primarily into two categories:

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44. Vanderholm et al., "Proposed CMS Star Rating."
45. Ark. Reg. 07-00, Regulation 7—Drug Products/Prescriptions (2014); 201 Ky. Admin. Regs. 2:280 (2020); and Wash. Rev. Code § 69.41.190 (2020).
46. Thomas Vanderholm et al., "State Approaches to Therapeutic Interchange in Community Pharmacy Settings: Legislative and Regulatory Authority," *Journal of Managed Care and Specialty Pharmacy* 24, no. 12 (2018).
47. Tracey Thornley et al., "A Feasibility Service Evaluation of Screening and Treatment of Group A Streptococcal Pharyngitis in Community Pharmacies," *Journal of Antimicrobial Chemotherapy* 71, no. 11 (2016).
48. Thornley, "Feasibility Service Evaluation," 3293.
49. See Glen J. Pearson, "Evolution in the Practice of Pharmacy—Not a Revolution!," *Canadian Medical Association Journal* 176, no. 9 (2007); and Teresa J. Schindel et al., "Perceptions of Pharmacists' Roles in the Era of Expanding Scopes of Practice," *Research in Social and Administrative Pharmacy* 13, no. 1 (2017).

(a) "adapting a prescription" allowed a pharmacist to make changes to an original prescription, such as by suggesting generic and therapeutic substitutions or by changing dosages, and required the pharmacist to inform the original prescribing physician of the changes, and (b) "initiating/managing drug therapy" allowed a pharmacist to select an appropriate drug therapy when proof of the pharmacist's competency had been established. By mid-2009, all registered pharmacists in Alberta had completed the required educational program to successfully adapt a prescription or prescribe in emergencies.[50] Early studies of the reforms in Alberta show a rapid rate of training on new responsibilities among pharmacists.[51]

While pharmacists themselves have been instrumental in pushing for many of these reforms, there seems to be considerable public interest in increased pharmacy services as well. For example, Kristin Darin conducted a study of consumer interest in community pharmacy testing for HIV and found significant interest among groups that have historically been affected by the disease.[52] She believes that allowing more pharmacists to test for HIV could be beneficial for local communities and that further consideration of the issue is warranted. However, despite such interest, the prescribing authority of pharmacists across the United States varies and generally remains quite limited. As of 2015, the vast majority of states had not granted significant autonomous prescribing authority to pharmacists.[53] Several states allowed varying degrees of prescribing authority for specific medications or pursuant to a practice agreement with a physician, but these kinds of allowances tend to be limited in both their scope and their impact. Such existing policies could stand to be substantially expanded. There is considerable evidence that pharmacists are perfectly equipped to perform basic testing and treatment services, and few if any downside risks seem to have accompanied this expanded authority where it has been allowed. Thus, Idaho, as well as the other

50. Nora MacLeod-Glover, "An Explanatory Policy Analysis of Legislative Change Permitting Pharmacists in Alberta, Canada, to Prescribe," *Internal Journal of Pharmacy Practice* 19, no. 1 (2011).
51. For example, one study found that "by April 1, 2007, over 2,800 (75 percent) pharmacists who were registered on the clinical registry had completed the orientation program necessary for prescribing to adapt a prescription or for an emergency encounter, and by September 1, 2007, over 3,300 (89 percent) had completed the program." See Nese Yuksel et al., "Prescribing by Pharmacists in Alberta," *American Journal of Health-System Pharmacy* 65, no. 22 (2008).
52. Kristin M. Darin et al., "Consumer Interest in Community Pharmacy HIV Screening," *Journal of the American Pharmacists Association* 55, no. 1 (January–February 2015).
53. Data from the Policy Surveillance Program, which is part of the LawAtlas Project at Temple University's Beasley School of Law. See Policy Surveillance Program, "Pharmacist Scope of Practice" (dataset), updated through July 1, 2015, http://lawatlas.org/datasets/pharmacist-scope-of-practice-1509023805.

jurisdictions discussed in this section, provides a potential roadmap for policymakers looking to increase access and care for patients in their region.

III. DISCUSSION

The changes introduced in Idaho H.B. 182 were likely the terminus of the state's efforts to expand pharmacists' prescribing authority—at least for now. The whole process began in 2011, when pharmacists were first given authority to prescribe minor supplements. By the end of its 2017 session, the state legislature had passed six separate bills to expand pharmacists' authority. Each time, legislation was passed despite the objections of interest groups that could stand to lose if pharmacists were allowed to prescribe medications. For example, the Idaho Medical Association was vocally opposed to many of these changes and opposed rulemaking efforts both during the negotiated rulemaking process at the Idaho Board of Pharmacy and state legislature and when statutory changes were considered by the legislature.[54]

One recurring objection was that without limitations on prescribing authority, pharmacists might prescribe without limitations or safeguards, perhaps going so far as to prescribe controlled substances or other medications that they lacked sufficient training to prescribe.[55] As the president of the American Medical Association (AMA) stated in a letter urging the governor to veto 2019 H.B. 182, "The AMA is deeply concerned this legislation grants pharmacists wide latitude to prescribe medications to patients, young and old, regardless of the severity or complexity of the patient's condition and including such illnesses as cancer, bipolar disorder, glaucoma, hypertension and diabetes."[56]

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54. See Idaho Senate Health and Welfare Committee, *Minutes*, January 10, 2018, 4, https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2018/standingcommittees/180110_sh&w_0300PM-Minutes.pdf; and Idaho House Health and Welfare Committee, *Minutes*, February 28, 2019, 2, https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2019/standingcommittees/190228_hhea_0800AM-Minutes.pdf.

55. See, for example, Idaho House Health and Welfare Committee, *Minutes*, February 24, 2017, 2, https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2017/standingcommittees/170224_hhea_0900AM-Minutes.pdf ("There is no Legislative direction on use of the broad authority and no guidance on the class of drugs. . . ."); Idaho Senate Health and Welfare Committee, *Minutes*, March 7, 2017, 3; Lawler, on behalf of Idaho Board of Medicine, to Adams, Idaho State Board of Pharmacy, October 24, 2017; and Idaho House Health and Welfare Committee, *Minutes*, February 28, 2019, 2 ("Controlled and compounded drugs, previously not allowed, are now allowed if an existing diagnosis is present."). Note that Idaho Code 54-1704 specifically prohibits the board of pharmacy from permitting pharmacists to prescribe controlled substances.

56. Madara, American Medical Association, to Idaho Governor Little, March 21, 2019, 1.

However, these fears have not materialized for several reasons. First, pharmacists in Idaho are held to a high standard of care within the profession and can be disciplined by the Idaho Board of Pharmacy for engaging in unprofessional conduct.[57] Second, many pharmacists remain wary of prescribing because their employers and pharmacies are subject to strict insurance policies, and they do not want to be found liable for any violations. As a result, many pharmacies that prescribe medications do so only after providing additional training to employees and putting additional safeguards in place.[58]

A second objection to some of Idaho's reforms was that there would be a breakdown in care coordination among healthcare providers, as well as between providers and state regulatory boards.[59] One fear was that pharmacists might prescribe medications but that this would not be communicated to a patient's other healthcare providers. For example, the then president of the Idaho Medical Association criticized 2017 H.B. 191 on the grounds that its expansion of pharmacists' prescriptive authority would undermine the use of patient-centered medical homes (a healthcare model often led by a primary care physician), because there would be less coordination between pharmacists and primary care providers. [60]

However, some Idaho pharmacists have argued that the regulatory changes have actually increased their collaboration with primary care providers, enabling pharmacists to provide patients a higher standard of care.[61] For one, the changes have permitted greater flexibility for pharmacists and other medical professionals if they decide to enter into collaborative practice agreements.[62] Previously, pharmacists had to delineate each specific drug and define

57. Idaho Code § 54-1726(a).
58. See Diana Yap, "Idaho Pharmacists Can Prescribe More Than 20 Categories of Medications," *Pharmacy Today* 24, no. 10 (October 2018).
59. See stated concern by Idaho Medical Association: Idaho Senate Health and Welfare Committee, *Minutes*, March 7, 2017, https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2017/standingcommittees/170307_sh&w_0300PM-Minutes.pdf; Idaho Senate Health and Welfare Committee, *Minutes*, January 10, 2018, 4 ("H 191 and this docket run counter to [the] effort [to coordinate and manage care as to prevent unnecessary duplication]"); stated concern by Idaho Medical Association in Idaho House Health and Welfare Committee, *Minutes*, January 25, 2017, 2 ("This fragments the intent to preserve health care integration."); and stated concern by Idaho Board of Medicine: Letter from Kathleen Rodes Sutherland, Idaho Board of Medicine, to Alex Adams, Idaho State Board of Pharmacy, October 11, 2017, https://bom.idaho.gov/BOMPortal/BOM/Laws_Rules/board_of_pharmacy_letter.pdf.
60. See Bruce Belzer, "Lawmakers Irresponsible to Give Pharmacists, Chiropractors More Medication Power," *Idaho Statesman,* March 14, 2017.
61. Danae Lenz, "BIG CHANGES: New Regulations, Changes to State Rules Are Keeping Pharmacies on Their Toes," *Idaho State Business Journal*, March 14, 2018.
62. A collaborative practice agreement allows another healthcare provider to delegate certain patient care functions to a pharmacist—such as ordering tests for the patient and modifying or terminating a prescription.

each permissible activity in their collaborative practice agreements.[63] Now such agreements are much easier to enter into, because they do not have to limit the specific drugs and actions the pharmacist can take.[64] Still, if a pharmacist is prescribing autonomously, safeguards remain in place to ensure continued communication between all healthcare providers.[65] For example, pharmacists must consult with other healthcare professionals if a particular form of treatment is beyond their training, notify their patient's primary care provider after prescribing a drug, and develop a follow-up care plan and document the prescription, among other requirements.

IV. CONCLUSION

The United States in general has seen large numbers of pharmacy closures in recent years.[66] Although the total number of pharmacies is still growing, nearly one in eight pharmacies closed in the United States between 2009 and 2015. Many of these pharmacies were independent or were located in low-income areas, especially urban areas that often serve publicly insured populations.[67] Idaho's regulatory changes, by allowing expanded use of telepharmacy, could help combat this troubling trend. Indeed, companies such as CVS are now flocking to Idaho, new pharmacies are being built in areas that have not seen one in decades, and pharmacists and pharmacy students are moving to the state for the chance to practice at the top of their profession.[68]

It should not be a surprise that removing restrictions on the ability of pharmacists to use the full extent of their knowledge and training tends to increase

63. See Idaho Admin. Code 27.01.04.200 (archived 2018), https://adminrules.idaho.gov/rules/2018%20Archive/27/270104.pdf.
64. Idaho Admin. Code 27.01.01.351 (temporary effective date June 30, 2019), https://adminrules.idaho.gov/rules/current/27/270101.pdf.
65. Idaho Admin. Code 27.01.01.350 (temporary effective date June 30, 2019), https://adminrules.idaho.gov/rules/current/27/270101.pdf.
66. Erin Michael, "US Pharmacies Closing at High Rate, Potentially Impacting Patient Health," *Healio*, November 1, 2019.
67. Jenny S. Guadamuz et al., "Assessment of Pharmacy Closures in the United States from 2009 through 2015," *JAMA Internal Medicine* 180, no. 1 (2020).
68. Davlin, "Board of Pharmacy Changes." For examples of recently opened pharmacies, see Julie Wootton-Greener, "Phoning It In: Telepharmacy Connects Rural Patients," *Times-News*, January 19, 2017; and Tellman, "Telepharmacy Key to New Victor Drug Store." Reportedly, additional students and faculty members have chosen to join the Idaho State University College of Pharmacy because of Idaho's expanded practice. See Idaho Senate Health and Welfare Committee, *Minutes*, March 5, 2019, 2, https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2019/standingcommittees/190305_sh&w_0300PM-Minutes.pdf.

access to care, services, and medications. Furthermore, contrary to some of the warnings made by certain interest groups that opposed these efforts, no significant downside risks have been realized to date. It is now within the professional judgment of pharmacists in Idaho to determine whether a medication fits within the standards established by the state legislature and the Idaho Board of Pharmacy.

Other states would be wise to learn from the experience of Idaho and to consider adopting similar reforms of their own. In Idaho, there no longer has to be a perennial fight over which medications are allowed or disallowed. Instead, decisions about which medication or treatment is the best fit for a patient are being left to those best suited to make them: patients, physicians, and pharmacists.

APPENDIX

TABLE A1. PHARMACY REFORMS IN IDAHO, 2011–2019

Legislation		
Year	Action	Description
2011	H.B. 218	• Allowed pharmacists to prescribe fluoride supplements and agents for active immunizations for individuals ages 12 and over
2015	H.B. 108	• Allowed pharmacists to prescribe opioid antagonists
2016	S.B. 1294	• Lowered minimum age at which active immunizations can be prescribed to six years
2016	S.B. 1322	• Allowed pharmacists to prescribe epinephrine auto-injectors
2017	H.B. 3	• Allowed pharmacists to prescribe tuberculin purified protein derivative products
2017	H.B. 4	• Allowed pharmacists to prescribe tobacco cessation products
2017	H.B. 191	• Granted the Idaho Board of Pharmacy wide discretion to allow pharmacists to prescribe minor medications that do not require a diagnosis, are related to minor conditions and are self-limiting, are diagnosable with a CLIA-waived test, or relate to an emergency
2018	H.B. 351	• Simplified procedures for reciprocal licensure • Allowed prescribers who diagnose an infectious disease in a patient to issue a prescription for someone who comes into contact with the patient • Eliminated licensing requirement for entities such as gas stations to sell small amounts of over-the-counter medications, such as packets of ibuprofen • Eliminated registration requirements for veterinary drug outlets • Allowed for orders using digital images of written prescriptions
2018	H.B. 339	• Allowed prescribers to authorize pharmacists to substitute for therapeutic equivalents
2019	H.B. 10	• Made it easier to send electronic prescriptions • Established a pharmacy practice interstate reciprocity agreement (similar to the nursing compact)
2019	H.B. 182	• Allowed pharmacists to prescribe without express authorization from board rules • Allowed pharmacists to prescribe medications for conditions that do not require a new diagnosis, are minor and self-limiting, have a CLIA-waived test to guide diagnosis, or need to be prescribed immediately because of emergency
Regulations		
Year	Action	Description
2017	Docket No. 27-0101-1602	• Reduced regulations on telepharmacy by allowing for easier registration, removing certain automated dispensing and storage requirements, and eliminating requirements for colocation with a medical care facility, among other things
2018	Docket No. 27-0104-1701	• Established standards and allowed pharmacists to prescribe medications to combat lice, cold sores, motion sickness, and uncomplicated urinary tract infections
2019	Docket No. 27-0104-1802	• Allowed pharmacists to prescribe medications to combat allergic rhinitis, mild acne, and mild cough

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