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# Expedited Partner Therapies for Sexually Transmitted Diseases: Legal and Policy Approaches<sup>1</sup>

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## I. Introduction

Since colonial times, sexually transmitted diseases (STDs) have plagued American society. STDs like syphilis, and more recently HIV/AIDS, have contributed to significant morbidity and mortality in the United States.<sup>6</sup> Even though major

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<sup>6</sup> Lawrence O. Gostin & James G. Hodge, Jr., *Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification*, 5 DUKE J. OF

advances have been made in detecting, treating, and preventing STDs, even common infections such as chlamydia and gonorrhea remain significant threats to the public's health.<sup>7</sup> The U.S. Centers for Disease Control and Prevention (CDC) estimates that over 700,000 new cases of gonorrhea<sup>8</sup> and 2.8 million new cases of chlamydia<sup>9</sup> occur each year in the United States. Each case affects not only the health of the person who has contracted one or more STDs, but also threatens the health of partners with whom infected persons engage in unprotected sexual behaviors.<sup>10</sup>

Not surprisingly, evaluating and treating the sexual partners of infected persons are critical components of prevention efforts<sup>11</sup> and essential to limiting the spread of STDs.<sup>12</sup> Traditional practices to inform, evaluate, and treat sexual partners have relied on patients or health care providers to notify partners of their potential exposure to STDs.<sup>13</sup> Partner management strategies became widely recommended for many STDs.<sup>14</sup> However, these strategies, particularly concerning gonorrhea and chlamydia, have only been marginally successful in assuring partner treatment. While assisting in identifying and locating at-risk sexual partners, these strategies frequently do not result in actual treatment of partners. Accordingly, untreated partners may continue to spread STDs, including reinfecting the existing patient. Without partner treatment, the cycle of STD transmission may continue unabated.

Public health officials recognize this limitation of existing partner management approaches and have devised a clever solution. Expedited partner therapy, or EPT, refers to the direct delivery of medications or prescriptions by a person infected with an STD to his or her sex partners. No clinical assessment of the patient's sex partners is

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GENDER L. & POL'Y 9 (1998).

<sup>7</sup> Lawrence K. Altman, *Sex Diseases Still Rising: Chlamydia Is Leader*, N.Y. TIMES, Nov. 14, 2007, at A17.

<sup>8</sup> CDC, *Gonorrhea – CDC Fact Sheet*, available at <http://www.cdc.gov/std/Gonorrhea/STDFact-gonorrhea.htm> (last visited Apr. 1, 2008).

<sup>9</sup> CDC, *Chlamydia – CDC Fact Sheet*, available at <http://www.cdc.gov/std/Chlamydia/STDFact-Chlamydia.htm> (last visited Apr. 1, 2008).

<sup>10</sup> *Id.*

<sup>11</sup> THOMAS PARRAN, M.D., *SHADOW ON THE LAND: SYPHILIS* (Reynal & Hitchcock 1937).

<sup>12</sup> CDC, *Sexually Transmitted Diseases Treatment Guidelines, 2006*, 55 MORBIDITY AND MORTALITY WEEKLY REP., No. RR-11, 5-6 (2006) (hereinafter *CDC STD Disease Treatment Guidelines*).

<sup>13</sup> James G. Hodge, Jr. & Lawrence O. Gostin, *Handling Cases of Willful Exposure Through HIV Partner Counseling and Referral Services*, 23 RUTGERS WOMEN'S RTS. L. REP. 45, 46 (2001).

<sup>14</sup> CDC, *Program Operations Guidelines for STD Prevention: Partner Services*, PS-1, available at <http://www.cdc.gov/std/program/partners.pdf> (last visited Apr. 1, 2008); CDC, *HIV Partner Services and Referral Services Guidance* (Dec. 30, 1998), available at <http://www.cdc.gov/hiv/resources/guidelines/pcrs/pdf/pcrs.pdf> (last visited Apr. 1, 2008).

required. Rather, health care practitioners (e.g., physicians, nurse practitioners, physician assistants, pharmacists, and public health workers) provide patients with sufficient medications either directly or via prescription for the patients and their partners. After evaluating multiple studies demonstrating the efficacy of EPT as a public health measure in specific settings, CDC recommended national use of EPT in 2006 for certain populations with chlamydia and gonorrhea.<sup>15</sup>

EPT can effectively reduce the prevalence and incidence of disease. By offering safe and effective medications directly to at-risk partners without clinical evaluation, EPT frequently increases patient-based partner notification and treatment rates, effectively closes an existing loop of transmission, and derails the future spread of STDs to the patient, partner, or others at risk of exposure. Yet implementation of EPT raises significant legal and policy questions. Is it legally permissible to provide prescription medications to the patient's partners when those partners have not undergone clinical evaluation? Are clinicians liable or subject to licensing sanctions for "third-party prescribing?" May patients be criminally sanctioned for providing treatment for STDs to their partners without a valid prescription from a licensed practitioner? Can pharmacists lawfully distribute prescription medications to patients if they know the drugs are to be used by the patients' partners? Who should pay for the partner's medications – the patient, the patient's health insurer, the partner, or public health authorities?

These and other concerns have the potential to stymie the practice of EPT. In 2005, Matthew Golden and colleagues surveyed state boards of medicine and pharmacy, finding that nearly 90% of boards perceived EPT as illegal or of "uncertain" legality, due in part to the fact that the legal issues have "simply never been addressed."<sup>16</sup> To address this gap, the *Centers for Law and the Public's Health: A Collaborative at Johns Hopkins and Georgetown Universities (Center)* collaborated with CDC beginning in September 2005 to assess the legal framework concerning EPT.<sup>17</sup> After conducting extensive legal reviews across all states and other jurisdictions, we concluded that despite potential legal impediments, the use of EPT to provide treatment and diminish the spread of STDs is legally defensible in many states and should be promoted through laws and policies that seek to protect the public's health.<sup>18</sup>

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<sup>15</sup> CDC STD Disease Treatment Guidelines, *supra* note 12, at 68.

<sup>16</sup> Matthew R. Golden et al., *The Legal Status of Patient-Delivered Partner Therapy for Sexually Transmitted Infections in the United States*, 32 SEXUALLY TRANSMITTED DISEASES 112, 112-114 (2005).

<sup>17</sup> Hodge et al., *supra* note 1, at 238-43.

<sup>18</sup> *Id.*

In this article, we explain these findings and suggest a series of options to facilitate the practice of EPT. We begin in Part II by addressing the public health burdens of gonorrhea and chlamydia (the specific STDs for which EPT is recommended), traditional public health approaches to partner notification, and the efficacy (and limits) of EPT as a tool for STD prevention.<sup>19</sup> Part III explores key legal issues surrounding licensing sanctions, public health requirements, liability, prescription drug laws, and reimbursement.<sup>20</sup> We frame and respond to the central legal issue underlying EPT – *whether a health care practitioner may provide a prescription for a non-controlled substance to a patient's sexual partner, absent prior evaluation of the partner, for the purposes of treating the partner for specific STDs*.<sup>21</sup> Part IV examines the legality of EPT across all states, D.C., and Puerto Rico by presenting the methodology and results of the legal assessment by the *Center* and CDC.<sup>22</sup> Through this analysis, we find that EPT is legally (1) *permissible* in 12 (23%) jurisdictions, (2) *potentially allowable* in 27 (52%) jurisdictions, and (3) *prohibited* in only 13 (25%) jurisdictions.<sup>23</sup> These findings suggest that the legal landscape in many jurisdictions supports, rather than rejects, the practice of EPT.

Still, significant legal and policy challenges confront practitioners trying to implement EPT in many states. In Part V, we proffer several law and policy options designed to facilitate the implementation of EPT to improve the public's health.<sup>24</sup> These include select reforms to: (1) expressly endorse EPT through statutory or regulatory enactments, facilitated by the creation of model statutory language; (2) adopt modern, updated national treatment guidelines; (3) create exceptions to constrictive prescription drug requirements; (4) seek increased medical or pharmaceutical board support for EPT; and (5) support insurance payments for partners' medications provided through patients.<sup>25</sup>

## II. EPT as a Tool for Public Health Prevention of Specific STDs

The emerging use of EPT as a tool for public health prevention is focused on STDs like chlamydia and gonorrhea that are proliferate across the United States, relatively easy to treat, and susceptible to reinfection.<sup>26</sup> STDs such as HIV/AIDS or

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<sup>19</sup> See discussion *infra* Part II.

<sup>20</sup> See discussion *infra* Part III.

<sup>21</sup> See discussion *infra* Part III.

<sup>22</sup> See discussion *infra* Part IV.

<sup>23</sup> See discussion *infra* Part IV(B).

<sup>24</sup> See discussion *infra* Part V.

<sup>25</sup> *Id.*

<sup>26</sup> See Hodge, et al., *supra* note 1.

syphilis that involve complex treatment regimens are not suitable conditions for the use of EPT because ongoing clinical care is essential to successful treatment.<sup>27</sup> *Chlamydia trachomatis* infection is the most commonly reported notifiable condition<sup>28</sup> in the United States with more than 1.031 million actual cases reported to state and local health departments in 2006, the most recent year for which surveillance data are available.<sup>29</sup> *N. gonorrhoeae* is the second most reported condition nationally with more than 358,000 cases reported in 2006.<sup>30</sup> Reported cases represent only a fraction of the true incidence of these infections because many cases are asymptomatic and not detected, or are simply not reported.<sup>31</sup> CDC estimates that 2.8 million Americans are infected with chlamydia<sup>32</sup> and about 700,000 are infected with gonorrhea<sup>33</sup> each year. African Americans are disproportionately affected: according to CDC, the ratio of infections between African Americans and Caucasians is 18:1 for gonorrhea, and 8:1 for chlamydia.<sup>34</sup>

Morbidity of these infections is significant because they are so common and can lead to long-term disabilities when untreated.<sup>35</sup> Both chlamydia and gonorrhea can result in serious complications, leading to high health care costs, especially among African-American women.<sup>36</sup> In men, gonorrhea can cause epididymitis, an infection in

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<sup>27</sup> *Id.*

<sup>28</sup> See Altman, *supra* note 7. For background on the CDC's collection and publication of data on nationally notifiable diseases and the most recent listing of them, see CDC, *Nationally Notifiable Diseases Surveillance System*, at <http://www.cdc.gov/epo/dphsi/nndsshis.htm> (last visited Apr. 1, 2008).

<sup>29</sup> See Altman, *supra* note 7.

<sup>30</sup> *Id.*

<sup>31</sup> S. Deblina Datta, et al., *Gonorrhea and Chlamydia in the United States Among Persons 14 to 39 Years of Age, 1999 to 2002*, 147 ANNALS INTERNAL MED. 89, 89.

<sup>32</sup> See Chlamydia – CDC Fact Sheet, *supra* note 9.

<sup>33</sup> See Gonorrhea – CDC Fact Sheet, *supra* note 8.

<sup>34</sup> See Altman, *supra* note 7. Interestingly, these racial disparities are not explained by differences in socioeconomic status or health behaviors such as illicit drug use, condom use or concurrence of sex partners, suggesting that population-level interventions such as the practice of EPT might be the most effective means for addressing racial disparities. See Denise Dion Hallfors, et al., *Sexual and Drug Behavior Patterns and HIV and STD Racial Disparities: The Need for New Directions*, 97 AM. J. PUB. HEALTH 126-32 (2007) (“factors other than individual risk behaviors and covariates appear to account for racial disparities, indicating the need for population level interventions.”); Thomas A. Farley, *Sexually Transmitted Diseases in the Southeastern United States: Location, Race, and Social Context*, 33 SEXUALLY TRANSMITTED DISEASES S58-S64 (2006) (“the racial disparity cannot be explained by traditional measures of socioeconomic differences, and it cannot be explained by individual-level determinants of sexual behavior, but rather reflects deeper group-level social and environmental factors for which race is a marker.”).

<sup>35</sup> See Chlamydia – CDC Fact Sheet, *supra* note 9.

<sup>36</sup> See Joanna E. Siegel, *The Economic Burden of Sexually Transmitted Disease in the United States*, in

the reproductive organ that is usually not serious but can lead to abscess or infertility if untreated. For women, chlamydia and gonorrhea are major causes of pelvic inflammatory disease, an infection of the reproductive organs that can lead to infertility, ectopic pregnancy, abscess formation, and chronic pelvic pain.<sup>37</sup> Pregnant women can pass the infection to their infants during delivery, which can lead to neonatal ophthalmia (an eye infection that can lead to blindness if untreated) and pneumonia. Recurrent infections with chlamydia and gonorrhea persists, particularly among sexually active young women,<sup>38</sup> and increase the risk of short- and long-term complications,<sup>39</sup> including the transmission of HIV infection.<sup>40</sup>

### A. Traditional Treatment Approaches

One of the most significant impediments to controlling the spread of STDs like chlamydia and gonorrhea is that “the sexual partners of people with sexually transmitted infections are likely to be infected but may be asymptomatic and may not otherwise seek care.”<sup>41</sup> For this reason, once a person is known to be infected with an STD, identifying and treating others who may be at risk of infection is a long-standing public health goal. Traditional strategies to identify, inform, evaluate, and treat infected patients’ sex partners have relied upon index patients and/or their health care providers to notify sexual partners that they should seek testing and appropriate medical care.<sup>42</sup> Partner management practices (including contact tracing<sup>43</sup> and partner notification,<sup>44</sup> or, as more

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SEXUALLY TRANSMITTED DISEASES 1367 (King K. Holmes, et al., eds., 3d ed. 1999).

<sup>37</sup> CDC, *Pelvic Inflammatory Disease – CDC Fact Sheet*, available at <http://www.cdc.gov/std/PID/STDFact-PID.htm> (last visited Apr. 1, 2008).

<sup>38</sup> See Linda M. Niccolai, et al., *Burden of Recurrent Chlamydia Trachomatis Infections in Young Women: Further Uncovering the “Hidden Epidemic,”* 161 ARCHIVES OF PEDIATRICS AND ADOLESCENT MED. 246 (2007).

<sup>39</sup> Researchers have estimated that as much as 48% of the morbidity of gonorrhea is attributable to reinfection. See Kyle T. Bernstein, et al., *Defining Core Gonorrhea Transmission Utilizing Spatial Data*, 160 AM. J. EPIDEMIOLOGY 51 (2004). See also Susan D. Hillis, et al., *Recurrent Chlamydial Infections Increase the Risks of Hospitalization for Ectopic Pregnancy and Pelvic Inflammatory Disease*, 176 AM. J. OBSTETRICS & GYNECOLOGY 103 (1997); Jami S. Leichter, et al., *STD REPEATERS: IMPLICATIONS FOR THE INDIVIDUAL AND STD TRANSMISSION IN A POPULATION* 354-73 (Springer US Ed. 2006).

<sup>40</sup> Douglas T. Fleming & Judith N. Wasserheit, *From Epidemiological Synergy to Public Health Policy and Practice: The Contribution of Other Sexually Transmitted Diseases to Sexual Transmission of HIV Infection*, 75 SEXUALLY TRANSMITTED INFECTIONS 3 (1999).

<sup>41</sup> Sarah Hawkes, et al., *Partner Notification for the Control of Sexually Transmitted Infections*, 327 BRIT. MED. J. 633 (2003).

<sup>42</sup> See Hodge & Gostin, *supra* note 13.

<sup>43</sup> Gostin & Hodge, *supra* note 6.

<sup>44</sup> James G. Hodge, Jr., *Partner Notification*, in *ENCYCLOPEDIA OF PRIVACY* (William G. Staples,

recently labeled, partner counseling and referral services<sup>45</sup>) were initially developed to control the spread of syphilis and later became widely recommended for gonorrhea and chlamydia.<sup>46</sup> These practices have not been very effective, however, in assuring notification and treatment of index patients' sex partners, particularly in urban areas with high rates of STDs.<sup>47</sup> As a result, partner treatment is rarely assured and reinfection and further spread are common.<sup>48</sup> Faced with the lack of sufficient public health resources to support provider-led notification and the ineffectiveness of patient-led notification, public health officials have sought innovative approaches to control the spread of bacterial STDs like chlamydia and gonorrhea. Increasingly, such strategies have included EPT.<sup>49</sup>

### B. Epidemiologic Evidence Supporting EPT

Health care practitioners administering EPT give the index patients antibiotics (often coupled with information about STD risks and where to find testing providers) to deliver directly to their sexual partners. No independent clinical assessment of the patient's partners is performed, although it is encouraged. Numerous studies have found reduced re-infection rates among patients in EPT programs compared to those who have not participated in such programs.<sup>50</sup> In four randomized control trials assessing the frequency of persistent and recurrent infection following EPT, compared to standard partner management for gonorrhea, chlamydial infection, or trichomoniasis,

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ed., Greenwood Publishing Group 2005).

<sup>45</sup> See Hodge & Gostin, *supra* note 13.

<sup>46</sup> See CDC, *Program Operations Guidance: Partner Services* (2000), available at <http://www.cdc.gov/std/program/partners.pdf> (last visited Apr. 1, 2008); CDC, *HIV Partner Services and Referral Services: Guidance* (1998), available at <http://www.cdc.gov/hiv/resources/guidelines/pcrs/pdf/pcrs.pdf> (last visited Apr. 1, 2008).

<sup>47</sup> In the hardest hit regions, public health departments are able to provide partner-notification services for less than 20% of patients with gonorrhea or chlamydial infection. Matthew R. Golden, et al., *Partner Notification for HIV and STD in the United States: Low Coverage for Gonorrhea, Chlamydial Infection, and HIV*, 30 SEXUALLY TRANSMITTED DISEASES 490 (2003).

<sup>48</sup> Matthew R. Golden, et al., *Effect of Expedited Treatment of Sex Partners on Recurrent or Persistent Gonorrhea or Chlamydial Infection*, 352 NEW ENG. J. MED. 676 (2005).

<sup>49</sup> Institute of Medicine, *THE HIDDEN EPIDEMIC: CONFRONTING SEXUALLY TRANSMITTED DISEASES* (National Academies Press 1997).

<sup>50</sup> Kristina Ramstedt, et al., *Contact Tracing in the Control of Genital Chlamydia Trachomatis Infection*, 2 INT'L J. STD AIDS 116, 118 (1991). See also Patricia Kissinger, et al., *Effectiveness of Patient Delivered Partner Medication for Preventing Recurrent Chlamydia Trachomatis*, 74 SEXUALLY TRANSMITTED INFECTIONS 331, 331, 333 (1998); Fred Nuwaha, et al., *Efficacy of Patient-Delivered Partner Medication in the Treatment of Sexual Partners in Uganda*, 28 SEXUALLY TRANSMITTED DISEASES 105, 105, 109-10 (2001).



the results varied by disease and gender, but were otherwise largely consistent. Chlamydial reinfection among index patients was reduced by approximately 20% through EPT and gonorrhea reinfection was reduced by nearly 50%, with reinfection rates typically lower for men than for women.<sup>51</sup> Follow-up interviews of participants in these studies indicated that EPT resulted in equivalent or increased partner notification rates and consistently increased treatment rates for both diseases.<sup>52</sup> EPT was also associated with lower frequencies of individual behaviors that would risk re-infection, including sexual re-exposure to untreated partners and unprotected sex with new partners.<sup>53</sup> Cost effectiveness studies have suggested that EPT may reduce the net costs of complications from chlamydia by about 50%.<sup>54</sup> These studies demonstrate that EPT has the potential to increase treatment of index patients' sex partners and reduce re-infection rates among index patients, thus decreasing morbidity and health care costs associated with gonorrhea and chlamydia.<sup>55</sup>

The benefits of EPT for reducing the public health burden of re-infection with chlamydia and gonorrhea and the associated increased risk of complications correspond to relatively small risks to partners receiving patient-delivered medications.<sup>56</sup> Because individuals who receive treatment through EPT are not clinically evaluated, there is a risk that complications from the STD for which they are receiving treatment or co-infection with other STDs, such as HIV, might be missed.<sup>57</sup> For example, if a female partner has already developed pelvic inflammatory disease, the single dose of antibiotics delivered by the index patient may be insufficient to fully treat her condition.<sup>58</sup> Lack of clinical evaluation may also represent a missed opportunity for education on risk reduction. Concerns about adverse reactions to the antibiotics used in EPT also arise.

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<sup>51</sup> See Golden, *supra* note 47, at 494-95. See also Patricia Kissinger, et al., *Patient-Delivered Partner Treatment for Male Urethritis: A Randomized, Controlled Trial*, 41 CLINICAL INFECTIOUS DISEASES 623, 628 (2005), available at <http://www.journals.uchicago.edu/doi/pdf/10.1086/432476> (last visited Apr. 1, 2008); Schillinger, et al., *Patient-Delivered Partner Treatment with Azithromycin to Prevent Repeated Chlamydia trachomatis Infection Among Women*, 30 SEXUALLY TRANSMITTED DISEASES 49, 49 (2003).

<sup>52</sup> Kissinger, *supra* note 51, at 628.

<sup>53</sup> See Golden, *supra* note 47, at 494-95; see also Kissinger, et al., *supra* note 50, at 331; Ramstedt, *supra* note 50, at 118.

<sup>54</sup> Maarten J. Postma, et al., *Cost-Effectiveness of Partner Pharmacotherapy in Screening Women for Asymptomatic Infection with Chlamydia Trachomatis*, 4 VALUE HEALTH 266, 271 (2001).

<sup>55</sup> *Id.* at 272.

<sup>56</sup> See Hodge & Gostin, *supra* note 13, at 45-46; see also Kissinger, et al., *supra* note 50, at 333.

<sup>57</sup> William M. Geisler, *Management of Uncomplicated Chlamydia Trachomatis Infections in Adolescents and Adults: Evidence Reviewed for the 2006 Centers for Disease Control and Prevention Sexually Transmitted Diseases Treatment Guidelines*, 44 CLINICAL INFECTIOUS DISEASES S77, S81 (2007).

<sup>58</sup> *Id.*

Serious adverse reactions, toxicity, or allergic reactions can occur with the antibiotic regimens commonly used for treatment of gonorrhea and chlamydia (e.g., fluoroquinolones, azithromycin, and cephalosporins), but they are rare, occurring in less than 2% of patients.<sup>59</sup>

### C. Use of EPT in Treatment Guidelines and Practice

Multiple surveys of primary care providers suggest that many have already used EPT for patients with gonorrhea and chlamydia.<sup>60</sup> Overall, about half of U.S. physicians who treat chlamydia and gonorrhea reported that they have used EPT, but few said that they use it most of the time. Based on these data, CDC researchers estimate that only about 8-14% of gonorrhea diagnoses and about 13-20% of chlamydia diagnoses involve the use of EPT.<sup>61</sup>

In 2006, after evaluating numerous studies demonstrating the success of EPT as a public health measure and weighing the potential benefits against the potential risks, CDC recommended the national practice of EPT for chlamydia and gonorrhea under certain circumstances.<sup>62</sup> CDC guidelines state, for example, that male patients should be given written materials on pelvic inflammatory disease to pass along to their female partners. Existing data do not support the use of EPT for trichomoniasis or syphilis in any populations, or for gonorrhea or chlamydia infection among men who have sex with men (MSM).<sup>63</sup> CDC was hesitant to recommend the use of EPT for MSM due to

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<sup>59</sup> See, e.g., Zmax (azithromycin), in PHYSICIANS' DESK REFERENCE 2583-86, 2585-86 (Thomson Healthcare, 61<sup>st</sup> ed. 2007); Suprax (cefixime), in PHYSICIANS' DESK REFERENCE 1843-46, 1845 (Thomson Healthcare, 61<sup>st</sup> ed. 2007); Vantin (cefpodoxime proxetil), in PHYSICIANS' DESK REFERENCE 2645-49, 2647 (Thomson Healthcare, 61<sup>st</sup> ed. 2007); Cipro (ciprofloxacin), in PHYSICIANS' DESK REFERENCE 2977-84, 2981 (Thomson Healthcare, 61<sup>st</sup> ed. 2007).

<sup>60</sup> Matthew Hogben, et al., *Patient-Delivered Partner Therapy for Sexually Transmitted Diseases as Practiced by U.S. Physicians*, 32 SEXUALLY TRANSMITTED DISEASES 101, 101-04 (2005); Matthew R. Golden, et al., *Partner Notification for Chlamydial Infections Among Private Sector Clinicians in Seattle-King County: A Clinician and Patient Survey*, 26 SEXUALLY TRANSMITTED DISEASES 543, 546 (1999); Linda M. Niccolai & Diana M. Winston, *Physicians' Opinions on Partner Management for Nonviral Sexually Transmitted Infections*, 28 AM. J. PREVENTATIVE MED. 229, 230 (2005); Meighan E. Rogers, et al., *Patient-Delivered Partner Treatment and Other Partner Management Strategies for Sexually Transmitted Diseases Used by New York City Healthcare Providers*, 34 SEXUALLY TRANSMITTED DISEASES 88, 88-91 (2007); Laura J. Packel, et al., *Patient-Delivered Partner Therapy for Chlamydia Infections: Attitudes and Practices of California Physicians and Nurse Practitioners*, 33 SEXUALLY TRANSMITTED DISEASES 458, 459-61 (2006).

<sup>61</sup> See Hogben, *supra* note 60, at 102.

<sup>62</sup> CDC STD Disease Treatment Guidelines, *supra* note 12, at 40, 45.

<sup>63</sup> *Id.*

heightened concern over the risk of missing an opportunity to screen partners for HIV based on observed rates of comorbid HIV infection among MSM.<sup>64</sup> In many regions, however, local epidemiologic data may provide sufficient reassurance that EPT is safe for the MSM population.<sup>65</sup>

### III. Overview of Legal Issues Concerning EPT

Although many reasons underlie the inconsistent use of EPT across the United States, a contributing factor is the perception that the practice is unlawful. In a 2005 survey of members of state medical and pharmaceutical boards, 88% of respondents reported that they perceived EPT as illegal or of “uncertain” legality.<sup>66</sup> In some cases survey respondents from the same jurisdiction differed in their opinions as to the legality of EPT.<sup>67</sup> In this Part, we seek to clarify the types of legal issues that may contribute to these perceptions by examining laws that affect whether EPT is permissible, including (1) licensing laws for health care practitioners, (2) public health treatment requirements and guidelines for STDs, and (3) potential liability themes. We also discuss laws affecting the implementation of EPT, including (1) laws regulating dispensation of prescription drugs, (2) state labeling requirements for prescriptions, and (3) insurance and reimbursement policies.

#### A. Laws Affecting Permissibility of EPT

##### *Licensing of health care practitioners and pharmacists.*

In the majority of states in which EPT is not explicitly authorized via statute or regulation, a primary legal issue is whether health care practitioners will be subject to discipline by state licensing boards for providing a prescription to a person who is not their patient (the patient’s partner) and whom the practitioner has not previously evaluated.<sup>68</sup> Providing access to prescription medications to persons with whom a clinician has not established a professional relationship with or examined is statutorily and/or administratively barred in some states.<sup>69</sup> These laws are designed to protect

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<sup>64</sup> *Id.* See also Joanne Stekler, et al., *Concurrent Sexually Transmitted Infections in Sex Partners of Index Patients with Bacterial STIs: Implications for Patient-Delivered Partner Therapy*, 40 CLINICAL INFECTIOUS DISEASES 787, 788 (2005).

<sup>65</sup> Hodge et al., *supra* note 17, at 242.

<sup>66</sup> Golden et al., *supra* note 16, at 113.

<sup>67</sup> *Id.*

<sup>68</sup> See *id.* at 114.

<sup>69</sup> See e.g., ALA. ADMIN. CODE r. 540-X-9.11 (2000); ARIZ. REV. STAT. ANN. § 32-1401(27)(ss) (2006); 844 IND. ADMIN. CODE 5-4-1(b) (2003); LA. ADMIN. CODE tit. 46, Pt. LIII, § 2515

patients and the public from potentially unscrupulous actors who may seek to distribute potentially harmful prescription drugs without proper clinical evaluations.<sup>70</sup> Sanctions for such misconduct can include censure, fines, suspension, or revocation of a practitioner's license.<sup>71</sup>

In addition, practitioners who use EPT may be subject to discipline for violating licensing regulations that limit the delegation of prescription drug distribution to licensed practitioners.<sup>72</sup> Because EPT may involve delegating distribution of prescription drugs to an unlicensed person (the patient), licensed practitioners may violate such laws when participating in EPT.<sup>73</sup> These laws reflect the principle that individuals should not have access to medications they do not need or that could be harmful if taken improperly. This concern is also reflected in regulations limiting the distribution of prescription drugs over the Internet or via telemedical encounters.<sup>74</sup>

Complicating matters further, different types of practitioners such as physicians, nurses, physicians' assistants, and pharmacists are often regulated under separate licensing laws.<sup>75</sup> Thus, even within a single jurisdiction, different practitioners may be restricted from practicing EPT depending on their licensing standards.<sup>76</sup> For example,

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(2004); MO. CODE REGS. ANN. tit. 20, § 2150-5.020 (2006); OKLA. STAT. tit. 59, §§ 509, 637 (2004); S.C. CODE ANN. REGS. 81-28 (2001); W. VA. CODE R. § 11-1A-12(12.2)(k) (2007).

<sup>70</sup> See e.g., ALA. ADMIN. CODE r. 540-X-9.11 (2000); ARIZ. REV. STAT. ANN. § 32-1401(27)(ss) (2006); 844 IND. ADMIN. CODE 5-4-1(b) (2003); LA. ADMIN. CODE tit. 46, Pt. LIII, § 2515 (2004); MO. CODE REGS. ANN. tit. 20, § 2150-5.020 (2006); OKLA. STAT. tit. 59, §§ 509, 637 (2004); S.C. CODE ANN. REGS. 81-28 (2001); W. VA. CODE R. § 11-1A-12(12.2)(k) (2007).

<sup>71</sup> See e.g., ALA. ADMIN. CODE r. 540-X-9.11 (2000); ARIZ. REV. STAT. ANN. § 32-1401(27)(ss) (2006); 844 IND. ADMIN. CODE 5-4-1(b) (2003); LA. ADMIN. CODE tit. 46, Pt. LIII, § 2515 (2004); MO. CODE REGS. ANN. tit. 20, § 2150-5.020 (2006); OKLA. STAT. tit. 59, §§ 509, 637 (2004); S.C. CODE ANN. REGS. 81-28 (2001); W. VA. CODE R. § 11-1A-12(12.2)(k) (2007).

<sup>72</sup> See CONN. GEN. STAT. § 20-14e(c) (1999); see also IDAHO ADMIN. CODE r. 27.01.01.184 (2005); 88 MD. OP. ATT'Y GEN. 88 (2003).

<sup>73</sup> See CONN. GEN. STAT. § 20-14e(c) (1999); accord IDAHO ADMIN. CODE r. 27.01.01.184 (2005); see also 88 MD. OP. ATT'Y GEN. 88 (2003).

<sup>74</sup> See, e.g., ALASKA ADMIN. CODE tit. 12, § 40.967 (2000); FLA. ADMIN. CODE ANN. r. 64B8-9.014 (2003); OKLA. ADMIN. CODE § 535:15-3-13 (2005).

<sup>75</sup> See ALA. ADMIN. CODE r. 610-X-5.11, 610-X-5.22 (2007) (providing that nurses and physician assistants may not prescribe for non-patients of supervising physician); OHIO REV. CODE ANN. § 4730.21 (LexisNexis 2008) (providing that physician assistants may not provide treatment for new patients without prior physician evaluation).

<sup>76</sup> See ALA. ADMIN. CODE r. 610-X-5.11, 610-X-5.22 (2006) (providing that nurses and physician assistants may not prescribe for non-patients of supervising physician); OHIO REV. CODE ANN. § 4730.21 (providing that physician assistants may not provide treatment for new patients without prior physician evaluation).

in a few states, pharmacists are subject to disciplinary action by the state licensing authority if they dispense a prescription and know, or have reason to know, that the prescription is not supported by a physician-patient relationship or prior evaluation.<sup>77</sup> These laws may prevent pharmacists from participating in EPT even if physicians are permitted to do so, thus reducing the likelihood that the partner will ultimately receive the prescription.<sup>78</sup> Controlled substance laws and regulations that place additional requirements on the distribution of certain drugs, however, do not apply to EPT because antibiotics used to treat chlamydia and gonorrhea are not controlled substances.

Most states' laws do not specify whether a prescription issued outside the physician-patient relationship or prior evaluation is a per se instance of physician misconduct. The question becomes whether such practice falls under a more generalized bar against unprofessional medical practice. To address this issue, a licensing authority typically examines the facts of the particular case to determine whether the practitioner deviated from norms of acceptable medical practice.<sup>79</sup> The outcome may depend on whether the decision-making body defines the scope of the practice broadly (applying to any prescription given to a non-patient not previously examined) or narrowly (acceptable when limited to conditions such as chlamydia or gonorrhea, for which EPT is supported by clinical and public health research).<sup>80</sup> A resulting tension for practitioners and medical boards arises: while as a general matter providing *any* prescription without a prior evaluation or physician-patient relationship is impermissible, the administration of EPT in the limited circumstances for which it has been studied could be deemed good medical and public health practice.<sup>81</sup>

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<sup>77</sup> See FLA. STAT. § 465.023; MICH. COMP. LAWS ANN. § 333.17751; OHIO ADMIN. CODE 4729:5-30(A); OKLA. ADMIN. CODE § 535:15-3-13(d); S.C. CODE ANN. § 40-43-86; TEX. OCC. CODE ANN. § 291.104; W. VA. CODE § 30-5-3.

<sup>78</sup> See FLA. STAT. § 465.023.

<sup>79</sup> See *Carloni v. De Buono*, 245 A.D.2d 970, 972 (N.Y. App. Div. 1997); *Balmir v. De Buono*, 237 A.D.2d 648, 649 (N.Y. App. Div. 1997); *Jones v. North Dakota. State Bd. of Med. Exam'rs.*, 691 N.W.2d 251 (N.D. 2005); *Reed v. State Med. Bd. of Ohio*, 833 N.E.2d 814 (Ohio Ct. App. 2005); *Royder v. State Med. Bd. of Ohio*, 2002 WL 31867888 (Ohio Ct. App. 2002); *State ex rel. Okla. Bd. Of Med. Licensure & Supervision v. Litchfield*, 103 P.3d 1111 (Okla. Civ. App. 2004); *State v. Ray*, 848 P.2d 46 (Okla. Civ. App. 1992); *Gale v. State Bd. of Med. Exam'rs.*, 320 S.E.2d 35 (S.C. Ct. App. 1984).

<sup>80</sup> Cf. *State ex rel. Okla. Bd. Of Med. Licensure & Supervision v. Litchfield*, 103 P.3d 1111, 1117 (Okla. Civ. App. 2004) (upholding sanctions against physician who provided prescriptions without establishing physician-patient relationship).

<sup>81</sup> See *id.* But see *CDC STD Disease Treatment Guidelines*, *supra* note 12, at 68.

*Public health treatment requirements concerning STDs.*

Health care practitioners practicing EPT may also run afoul of state public health laws. State public health agencies may promulgate regulations regarding the treatment of STDs that require practitioners to take certain actions concerning the treatment of persons with STDs. Violations of these regulations may carry civil fines or criminal misdemeanor penalties. Some states, for example, *require* examination of all persons seeking treatment for STDs<sup>82</sup> or allow treatment only if the person is found to have the condition.<sup>83</sup> In addition, most states require physicians to report all cases of STDs to public health authorities. Administering EPT may compromise such reporting for the patient's partners whose identities and diagnoses may be unknown. In these states, EPT may conflict with the public health authorities' legally-prescribed protocols for the treatment of STDs, even though EPT is a proven way to prevent the spread of STDs.

*Public health regulations supporting EPT.*

Alternatively, state public health regulations may support EPT even if they do not specifically authorize it. A state public health authority may allow non-patient specific (a/k/a "standing order") treatment protocols for certain STDs.<sup>84</sup> For example, in Utah, a physician may write a standing order prescription that does not include a patient's name or the date for the treatment of STDs.<sup>85</sup> The prescription is then filled out and provided to the patient by a nurse.<sup>86</sup> This type of protocol may facilitate anonymous treatment of STDs or treatment of persons whom the physician has not examined, or with whom the physician has not established a physician-patient relationship.

More commonly, states' regulations incorporate by reference the recommendations of published treatment guidelines such as CDC's *STD Treatment Prevention Guidelines* (which currently recommend EPT) or the American Public Health Association's (APHA) *Control of Communicable Diseases Manual*.<sup>87</sup> Nevada, for example,

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<sup>82</sup> See ILL. ADMIN. CODE tit. 77 § 693.50(a)(3); 902 KY. ADMIN. REGS. 2:080; VT. STAT. ANN. tit. 18, § 1093.

<sup>83</sup> See IOWA CODE ANN. 139A.34; WASH. ADMIN. CODE § 246-100-203.

<sup>84</sup> See MINN. STAT. ANN. §§ 148.235, 151.37; UTAH CODE ANN. § 58-17b-620.

<sup>85</sup> UTAH CODE ANN. § 58-17b-620(3).

<sup>86</sup> *Id.* at § 58-17b-620(3)(b).

<sup>87</sup> CDC *STD Disease Treatment Guidelines*, *supra* note 12; AM. PUB. HEALTH ASS'N., CONTROL OF COMMUNICABLE DISEASE MANUAL (David L. Heymann ed., 18th ed. 2004). For states that incorporate one or both of these guidelines by reference, see ALASKA ADMIN. CODE tit. 7, §

requires health care providers to treat chlamydia and gonorrhea pursuant to the CDC's Guidelines.<sup>88</sup> Provided that these guidelines recommend EPT for certain conditions, they would be incorporated into the state's regulations as an accepted treatment practice. To the extent that medical or other licensing boards look to these guidelines for guidance, the practice of EPT may increasingly be viewed as within the standards of acceptable medical practice for the treatment of gonorrhea and chlamydia.

Even in states where laws prohibit practitioners from providing prescription drugs to patients who the practitioner has not physically examined, the adopted treatment guidelines may potentially allow EPT by creating a limited exception to the general laws barring provision of prescription drugs to non-patients or persons not yet evaluated.<sup>89</sup> Other states allow public health authorities to establish treatment standards for STDs and other communicable diseases that are consistent with medical and epidemiologic evidence, which may lead to the adoption of EPT as acceptable treatment practice for gonorrhea and chlamydia.<sup>90</sup>

### *Liability.*

Potential liability of health care practitioners and patients is a pervasive concern under EPT. Patients may fear criminal liability for delivering drugs to their partners via EPT. Some jurisdictions make it illegal for anyone to sell, distribute, or dispense prescription drugs for the treatment of an STD except pursuant to a valid prescription by an authorized health care practitioner.<sup>91</sup> These laws may expose patients to criminal misdemeanor sanctions if their acts of giving medications to partners to treat STDs are considered distribution of drugs in the absence of a valid prescription. These provisions may be especially problematic if the clinician's original prescription refers only to the patient, rather than the partner, as the ultimate user.

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27.010; 007-26-001; ARK. CODE R. § I; D.C. MUN. REG. tit. 22, §§ 202.8; 410 IND. ADMIN. CODE 1-2.3-59; 1-2.3-67; 10-155-258; ME. CODE R. § 5; MD. CODE REGS. §§ 10.06.01.01, 10.06.01.07; MO. CODE REGS. ANN. tit. 19, § 20-20.040; MONT. ADMIN. R. 37.114.515, 37.114.530; 173 NEB. ADMIN. CODE § 1-006; NEV. ADMIN. CODE §§ 441A.200, 441A.490, 441A.540; 10A N.C. ADMIN. CODE 41A.0201, 41A.0204; S.C. CODE ANN. REGS. 61-20; S.D. ADMIN. R. 44:20:03:01; UTAH ADMIN. CODE r. 386-702-12; 12 VA. ADMIN. CODE § 5-90-100; WASH. ADMIN. CODE 246-100-036; WIS. ADMIN. CODE [HFS] § 145.22.

<sup>88</sup> NEV. ADMIN. CODE §§ 441A.490, 540 (1989).

<sup>89</sup> See 844 IND. ADMIN. CODE 5-4-1(b); 410 IND. ADMIN. CODE 1-2.3-59; 1-2.3-67.

<sup>90</sup> See ALA. CODE § 420-4-1.05; ME. REV. STAT. ANN. tit. 22, § 807; MD. CODE REGS. 10.06.01.06; N.Y. COMP. CODES R. & REGS. tit. 10, § 23.2; 12 VA. ADMIN. CODE § 5-90-100.

<sup>91</sup> See ALA. CODE § 22-11A-21; MD. CODE ANN. CRIM. LAW § 10-103; OKLA. STAT. tit. 59 § 1-521.

Practitioners may also be concerned about their potential criminal liability as an accessory to the patient's criminal acts. However, physicians are more likely to be concerned primarily with the potential to be sued by patients or their partners for injuries resulting from EPT on medical malpractice grounds.<sup>92</sup> Claims of medical malpractice against physicians using EPT in cases of chlamydia and gonorrhea are theoretically possible, but highly unlikely for a very simple reason: the risks of significant harm to partners are virtually none. To establish a malpractice claim the partner must be injured as a result of receiving and taking an unauthorized prescription without prior examination. Because the risk of adverse reactions to the type of antibiotics used in EPT is low and can be managed with reasonable precautions, the threat of medical malpractice, though theoretically possible, is comparably low. We have not uncovered a single reported case of a clinician being sued for malpractice by anyone, whether patient or partner, solely for harms resulting from taking antibiotics for STDs like chlamydia and gonorrhea. The few cases that relate to EPT usually involve court review of a board decision to revoke a physician's license, but not medical malpractice.<sup>93</sup>

## **B. Laws Affecting Implementation of EPT**

Other laws, including regulations of prescription drug dispensation, labeling, and insurance and reimbursement policies, may not bar EPT entirely within a state but rather affect its implementation.

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<sup>92</sup> See Packel et al., *supra* note 60.

<sup>93</sup> See *Jones v. North Dakota State Bd. of Med. Examrs.*, 691 N.W.2d 251, 258 (N.D. 2005) (upholding revocation of physician's license for prescribing over the Internet without prior examination or physician-patient relationship); *Reed v. State Med. Bd. of Ohio*, 833 N.E.2d 814, 825 n.4 (Ohio Ct. App. 2005) (upholding revocation of physician's license when she prescribed extra doses of antibiotic to a patient who insisted on giving extra doses to her husband); *Royder v. State Med. Bd. of Ohio*, 2002 WL 31867888 (Ohio Ct. App. 2002) (upholding revocation of physician's license for failing to evaluate new patients before giving a prescription, and instead delegating to a physician assistant); *State ex rel. Oklahoma Bd. of Med. Licensure and Supervision v. Litchfield*, 103 P.3d 1111, 1114-15, 1117 (Okla. Civ. App. 2004) (upholding suspension of physician's license and finding of misconduct when physician prescribed to patients without establishing a physician-patient relationship or prior examination); *Carloni v. De Buono*, 245 A.D.2d 970, 972 (N.Y. App. Div. 1997) (upholding revocation of physician's license for misconduct, including issuing a prescription without prior examination); *Balmir v. De Buono*, 237 A.D.2d 648, 649 (N.Y. App. Div. 1997) (upholding revocation of physician's license for refilling prescriptions that were inconsistent with physical finding where patients produced empty medication bottles); *State v. Ray*, 848 P.2d 46, 47 (Okla. Civ. App. 1992) (upholding disciplinary action against physician for filling prescription without establishing "doctor/patient relationship and/or examination"); *Gale v. State Bd. of Med. Exam'rs*, 320 S.E.2d 35, 38 (S.C. Ct. App. 1984) (upholding revocation of physician's license when physician wrote prescriptions outside of physician-patient relationship).



*Dispensation of prescription drugs.*

Laws that limit dispensation of prescription drugs by practitioners to their patients (directly giving patients prescription drugs as opposed to giving the patient a prescription order for drugs) may prevent practitioners from utilizing EPT because to do so may involve dispensing prescription drugs to a person who is not the practitioner's patient.<sup>94</sup> In Michigan, for example, a prescribing practitioner can only *dispense* prescription drugs to the practitioner's own patients, but the law is silent about whether a practitioner can *prescribe* for persons other than his or her own patients.<sup>95</sup>

Although a practitioner may still practice EPT by writing a prescription for the patient's partner to be dispensed at a pharmacy, the practitioner would not have the option of dispensing an "extra dose" directly to the patient to give to his or her partner. In other words, a clinician could not simply provide the patient with a double dosage of antibiotics with instructions to provide one dose to the partner. Instead, the clinician would have to write a distinct prescription for the partner. This would require patients to reveal their partners' identities, raising health information privacy concerns.

Similarly, pharmacy regulations that limit dispensation of prescription drugs to the "ultimate user" could interfere with the practice of EPT.<sup>96</sup> Under such requirements, a pharmacist would not be allowed to knowingly give an extra dose to the patient for his or her partner (even if the clinician authorized it via prescription). The partner could come in to receive his or her own prescription, but the separate trip to the pharmacy may lower the number of partners obtaining treatment for the STD, thus reducing the efficacy of EPT.

*Patient identification requirements for prescriptions.*

Laws requiring prescription orders or labels to identify the person for whom the prescription is intended may also affect implementation of EPT. In Montana, for example, a prescription must bear the patient's name and address.<sup>97</sup> If identifying information is required, a physician may not be legally permitted to provide a blank prescription or an "extra dose" for the patient to deliver to the partner. Instead, a

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<sup>94</sup> See ALA. ADMIN. CODE r. 610-X-5.11, 610-X-5.22; MD. CODE ANN., HEALTH-OCC. § 12-102; MICH. COMP. LAWS ANN. § 333.17745.

<sup>95</sup> MICH. COMP. LAWS ANN. § 333.17745.

<sup>96</sup> See ARK. CODE ANN. § 17-92-505; HAW. REV. STAT. § 328-16(b)(3); KAN. STAT. ANN. § 65-1626(g); 247 MASS. CODE REGS. 2.00 (2008).

<sup>97</sup> MONT. CODE ANN. § 37-7-101.

prescription may have to be made out in the partner's name, again raising privacy concerns and logistical challenges. Furthermore, additional informational requirements about the partner, such as address or birth date, may hinder the ability of a practitioner to write a valid prescription for the partner if the patient does not know or is unwilling to share such information about the partner. This raises multiple legal issues, primarily those discussed previously regarding the legality of prescribing to a person with whom the practitioner does not have a relationship and whom the practitioner has not evaluated.

#### *Insurance and reimbursement.*

Finally, insurance and reimbursement policies may affect the feasibility of EPT. Who should pay for the extra dose of antibiotics distributed to the patient for the partner? Should a patient's health insurance provider cover the costs of two doses, even though the partner (who may not be insured by the same provider or at all) is the recipient of the extra dose? Denying payment for these medications, while antithetical to public health promotion, may be routine policy for insurance providers who are not obligated to pay for the treatment of anyone other than the insured, even where nonpayment may increase future costs for the insured due to reinfection or complications.<sup>98</sup>

### **IV. Comprehensive Assessment of the Legal Status of EPT**

Against this backdrop of perceived and actual legal issues confronting the practice of EPT in many states, the *Center* and CDC analyzed laws and policies across all states, the District of Columbia, and Puerto Rico, to assess the legality of EPT. Key legal provisions and policies were examined to respond specifically to a central inquiry: *whether a physician or other health care provider may provide a prescription for a non-controlled substance to a patient's partner, without prior evaluation of the partner, for the purposes of treating the partner for specific STDs.* The main presumption underlying our assessment and findings is the absence of a pre-existing physician-patient relationship or physical examination between the health care provider and the patient's partner.

#### **A. Methodology**

The *Center's* assessment entailed an examination of pertinent laws in each jurisdiction to ascertain whether they (1) expressly or implicitly approve of or reject EPT

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<sup>98</sup> Hodge et al., *supra* note 17.

or like practices, or (2) support the practice of EPT where laws, coupled with policy directives, potentially allow for its implementation. As discussed in Part III.B below, through careful interpretation of the legal environment, we classified each jurisdiction as to whether it permits, potentially allows, or prohibits EPT. While our assessment does not comprehensively analyze all laws that may be implicated by EPT in each jurisdiction and should not be considered as providing specific legal advice in any jurisdiction, we address the key legal issues discussed in Part III above.

First, we systematically reviewed existing statutes and regulations that expressly authorized (or prohibited) EPT or similar practices. Relevant provisions were found in laws governing the establishment of the physician-patient relationship, defining clinicians' authority to prescribe and delegate treatment, and setting forth requirements for the treatment of communicable diseases. We also examined introduced bills that would expressly authorize EPT.

The next source of law we examined were judicial decisions that implicate the legality of EPT. While there have been no reported cases specifically concerning EPT, relevant cases in a number of jurisdictions have addressed whether providers may be sanctioned for prescribing medications for non-patients without prior examination. In *Reed v. State Medical Board of Ohio*,<sup>99</sup> for example, an Ohio appellate court upheld the medical board's revocation of a physician's license because the physician, among other offenses, prescribed a triple dose of the antibiotic amoxicillin to a patient who insisted upon giving the extra doses to her husband.<sup>100</sup> This act was considered to be contrary to the accepted standards of the medical profession. Other cases, while relevant, are not dispositive regarding the legality of EPT because they address the prescription of controlled substances, which, as noted earlier, are subject to separate, additional restrictions beyond those applicable to the antibiotics used for EPT.<sup>101</sup>

We also looked closely at state administrative opinions, including recommendations by medical and pharmacy boards and opinions by Attorneys General, because of the significant weight that courts and decision-makers give these opinions in interpreting statutes and regulations. Where statutes or regulations are ambiguous or silent about the legal status of EPT, these opinions shed light on whether EPT comports with the established standard of care in a jurisdiction. For example, Iowa's

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<sup>99</sup> 833 N.E.2d 814 (Ohio Ct. App. 2005).

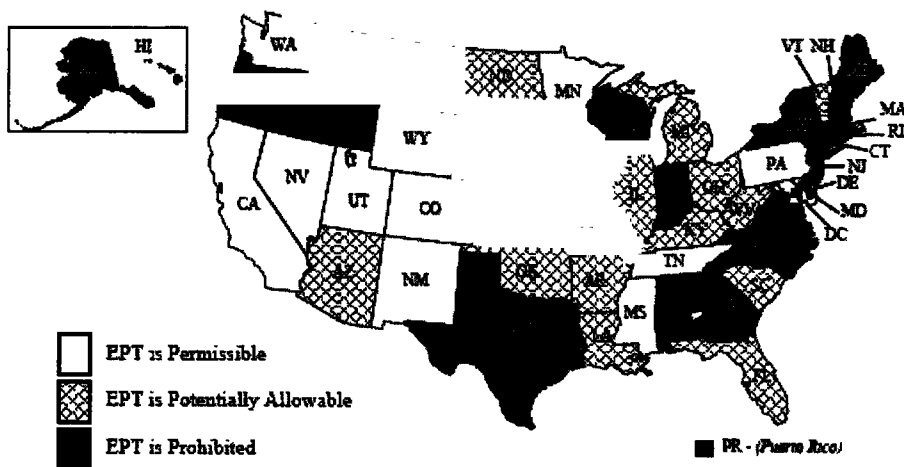
<sup>100</sup> *Id.* at 825, N. 4.

<sup>101</sup> See *State ex rel Oklahoma Bd. of Med. Licensure and Supervision v. Litchfield*, 103 P.3d 1111, 1114-15, 1117 (Okla. Civ. App. 2004) (upholding findings of misconduct when anesthesiologist prescribed controlled substances without examination or physician-patient relationship).

Attorney General addressed whether a physician had to be present while his agent administered a prescription drug, opining that supervision of the agent under the Iowa Pharmacy Practice Act does not necessarily require the physical presence of the physician.<sup>102</sup> The Iowa Attorney General felt that this practice was consistent with the proposed rules of the Iowa Board of Pharmacy Examiners and the Board of Medical Examiners.<sup>103</sup> Still, the Iowa Attorney General cautioned that it was not issuing a conclusive determination as to what qualifications an agent must have to administer prescription drugs.<sup>104</sup> Consequently, it implicitly left open the possibility that patients may deliver prescriptions to their sexual partners via EPT without the physician being present.

### B. National Legal Assessment of EPT

Based on the comprehensive legal assessment discussed above, the legality of EPT in each jurisdiction was classified into three categories: (1) EPT is permissible, (2) EPT is potentially allowable, and (3) EPT is prohibited. Figure 1, below, illustrates these findings for each jurisdiction.



<sup>102</sup> STATE OF IOWA, OFFICE OF THE ATTORNEY GEN., NO. 00-11-7, AUTHORITY OF PHARMACIST TO ADMINISTER PRESCRIPTION DRUGS PURSUANT TO WRITTEN PROTOCOL OF PHYSICIAN (2000), 2000 IOWA AG LEXIS 44.

<sup>103</sup> *Id.* at 8-10.

<sup>104</sup> *Id.* at 12.

### 1. EPT is Permissible

Any jurisdiction in which laws expressly authorize the implementation of EPT for the treatment of STDs was designated as “EPT is permissible.” Among the twelve total jurisdictions in which EPT was deemed legally permissible, four (CA, MD (Baltimore), MN, and TN) feature express statutory language permitting its implementation.<sup>105</sup> In California, for example, a physician who diagnoses chlamydia, gonorrhea, or other sexually transmitted infections, “may prescribe, dispense, furnish, or otherwise provide prescription antibiotic drugs to that patient’s sexual partner or partners without examination of that patient’s partner or partners.”<sup>106</sup> Similarly, in Tennessee, a physician may “[p]rovide to the treated patient non-named signed prescriptions for, or dispense to the patient, the appropriate quantity and strength of azithromycin [for the treatment of chlamydia] sufficient to *provide curative treatment for the total number of unnamed “partners”* [of the patient]. . . .”<sup>107</sup> In such instances, the authorization of EPT or like practices is limited to the treatment of specific diseases (e.g., chlamydia or gonorrhea) under particular circumstances. However, its legality in these states is virtually unquestionable.

In the absence of any express statutory or regulatory authorization, EPT was also deemed permissible in eight jurisdictions in which (1) advisory opinions recommend its use, or (2) guidelines supporting its use were incorporated by reference via regulations governing the treatment of STDs. While administrative board opinions are not themselves binding legal precedent, they are afforded significant weight and judicial deference.<sup>108</sup> Moreover, advisory opinions prescribe or prohibit practices consistent with the Boards’ own view of the prevailing standard of care requirements, which they apply to licensees in disciplinary proceedings.<sup>109</sup> In Colorado, for example, there were no statutes or regulations expressly authorizing or precluding EPT or like practices. However, the Colorado Medical Board of Examiners opined that “[t]reating partners of patients with sexually transmitted infections is generally considered acceptable and desirable if the partner will not seek treatment from his or her primary healthcare provider.”<sup>110</sup> In Nevada, regulations automatically recognize the most current version

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<sup>105</sup> CAL. HEALTH & SAFETY CODE § 120582 (West 2007); MD. CODE ANN., HEALTH—GEN. § 18-214.1 (West 2007); MINN. STAT. §§ 148.235, 151.37 (2008); TENN. COMP. R. & REGS., 1050-2-.13(9)(d) (2007); TENN. COMP. R. & REGS. 0880-2-.14 (2007).

<sup>106</sup> CAL. HEALTH & SAFETY CODE § 120582 (West 2007).

<sup>107</sup> TENN. COMP. R. & REGS. 1050-2-.13(9)(d) (2007) (emphasis added).

<sup>108</sup> See *Legal Status of Expedited Partner Therapy*, *supra* note 1.

<sup>109</sup> *Id.*

<sup>110</sup> COLO. STATE BD. OF MED. EXAM’RS, APPROPRIATENESS OF TREATING PARTNERS OF PATIENTS WITH SEXUALLY TRANSMITTED INFECTIONS, POL’Y NUMBER 40-10 (2001), *available at*

of CDC's *STD Treatment Guidelines* as the appropriate standard of care for the treatment of STDs.<sup>111</sup> Moreover, Nevada's regulations mandate adherence to the guidelines for the treatment of chlamydia and gonorrhea.<sup>112</sup> Provided that other laws do not preclude the practice of EPT, these opinions, or the incorporation by reference of modern STD treatment guidelines, suggest a favorable legal environment in which EPT is permissible. As discussed in the following subsection, this conclusion is distinguishable from jurisdictions with favorable policy opinions or that incorporate the CDC guidelines by reference against a backdrop of statutes or regulations that do not expressly support EPT or like practices.

## 2. EPT is Potentially Allowable

In jurisdictions in which laws do not expressly authorize or prohibit the practice of EPT, its legality may be inconclusive. Subject to reasonable interpretations of law, EPT is potentially allowable in twenty-seven jurisdictions (see Figure 1). In some states, the applicable statutes and regulations are silent as to whether a practitioner can prescribe antibiotics to a person who is not a patient without a prior examination.<sup>113</sup> In other states, statutes and regulations governing health care providers and pharmaceutical requirements are ambiguous or contradictory concerning prescriptions for non-patient, third-party consumers. Laws that do not unequivocally contemplate third-party prescriptions may not be relied upon to support the legality of EPT. In New Jersey, for example, the state department of health may provide antibiotics and other appropriate drugs for the treatment and prevention of STDs.<sup>114</sup> On its face, this statute allows the health department to dispense medications to treat STDs without demarcating clear boundaries that either expand or constrict third-party prescriptions.<sup>115</sup> However, another New Jersey statute provides that a prescription "means a lawful order of a practitioner for a drug, a device or a diagnostic agent for a *specific patient*."<sup>116</sup> This provision requires lawful prescriptions to be issued to a specified patient, or someone who has typically established a relationship with a health care provider and presumably undergone a physical examination.<sup>117</sup> Because the practice of EPT involves prescribing

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<http://www.dora.state.co.us/Medical/policies/40-10.pdf> (last visited Apr. 1, 2008).

<sup>111</sup> NEV. ADMIN. CODE § 441A.200 (2006).

<sup>112</sup> NEV. ADMIN. CODE § 441A.490 (2007); NEV. ADMIN. CODE § 441A.540 (1992).

<sup>113</sup> States whose licensing and public health laws are silent regarding the ability of practitioners to prescribe without prior examination or physician-patient relationship include: Delaware, Georgia, Idaho, Kansas, Mississippi, New Hampshire, and Rhode Island.

<sup>114</sup> N.J. STAT. ANN. § 26:4-47 (West 2007).

<sup>115</sup> *See id.*

<sup>116</sup> N.J. STAT. ANN. § 45:14-41 (West 2006) (emphasis added).

<sup>117</sup> *See id.*

drugs to a specified patient (and a partner), it may not violate New Jersey law *per se*. The legality of EPT, however, is ambiguous since neither statutory provision expressly authorizes nor precludes third-party prescriptions for treating STDs. Consequently, EPT is potentially allowable in New Jersey.

The ambiguity of third-party prescriptions is compounded by the effect of pharmaceutical requirements. While a patient's sexual partners are not legally *patients*, they are the persons for whom the prescriptions are intended. Some jurisdictions, such as Massachusetts, define "dispensing" as a "physical act" of delivery to "an ultimate user."<sup>118</sup> In such cases, pharmacists must presumably limit dispensation of the drug to the partner and use the partner's name and address on the prescription label, as required by regulations. Still, the lack of express statutory preclusions, coupled with the introduction of a prior bill to support EPT,<sup>119</sup> suggests that the legal landscape in a state like Massachusetts may also potentially allow EPT in practice.

Finally, as mentioned above, some states have administrative opinions favorable to EPT or incorporate by reference treatment guidelines recommending EPT, but other laws or regulations within the same state undermine the practice of EPT. In Indiana, public health regulations incorporate by reference the CDC's guidelines for the treatment of chlamydia and gonorrhea,<sup>120</sup> but elsewhere Indiana statutorily bars physicians from prescribing or dispensing prescription drugs to those the physician has never examined.<sup>121</sup> EPT may be allowable if the regulations incorporating the CDC guidelines are seen as creating a narrow exception to the general statutory ban on prescribing without prior examination.

### 3. *EPT is Prohibited*

Thirteen states expressly preclude EPT or like practices pursuant to statutes, regulations, policies, or a combination thereof (see Figure 1). In South Carolina, for example, "[i]t is unprofessional conduct for a physician to prescribe drugs to an individual without first establishing a proper physician-patient relationship."<sup>122</sup> In Illinois, "if a physical examination or necessary laboratory examination has not been performed" for the treatment of syphilis, gonorrhea, or chlamydia, health officials must

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<sup>118</sup> 247 MASS. CODE REGS. 2.00 (2008)

<sup>119</sup> S.B. 650, 183rd Gen. Court, Reg. Sess. (Mass. 2003).

<sup>120</sup> 410 IND. ADMIN. CODE 1-2.3-59 (2006); 410 IND. ADMIN. CODE 1-2.3-67 (2006).

<sup>121</sup> 844 IND. ADMIN CODE 5-4-1(b) (2003).

<sup>122</sup> S.C. CODE ANN. REGS. § 81-28(A) (2007).

“request that individual to report for such examination.”<sup>123</sup> Under this statutory mandate, sexual partners of patients with STDs must be physically examined prior to receiving prescription treatment.<sup>124</sup>

Legal obstacles in other jurisdictions stem from pharmaceutical requirements. In Michigan, pharmacists can only dispense prescriptions pursuant to an existent physician-patient relationship.<sup>125</sup> Although a single legal provision may not amount to a categorical denial of EPT’s legality, the collective laws and policies were read as mutually enforcing. Consequently, deference was given to the express language of existing statutes and regulations. Where legal provisions clearly impeded the implementation of EPT and there was an absence of other supporting laws or policies (as may exist in jurisdictions where EPT is permissible or potentially allowable), EPT was determined to be prohibited within that jurisdiction.

## V. Evaluation of Legal and Policy Options to Facilitate EPT

Contrary to perceived illegalities suggested by Golden’s survey,<sup>126</sup> the *Center’s* assessment revealed that EPT is legally permissible or potentially allowable in the majority (thirty-nine) of U.S. jurisdictions.<sup>127</sup> These differing conclusions may be explained in part by the fact that the previous survey was based on non-legal opinions proffered by physicians and pharmacists,<sup>128</sup> while the *Center’s* findings stemmed from a methodical legal assessment of relevant laws and policies within each jurisdiction.<sup>129</sup> There are, however, limits to the *Center’s* analysis. Notably, legal interpretations vary extensively. The *Center’s* assessment has not been fully validated among public health legal counsel, legislators, members of the judiciary, and others on a jurisdictional level. Changes in legally-binding factors (e.g., statutory enactments, adoption of specific STD practices) and the influence of non-binding legal sources, such as medical and pharmacy board policies or Attorney General opinions, may instantly alter the legal environment in each jurisdiction. Public health authorities, health care professionals, and policymakers must weigh existing law and policy options and interpretations. Recognizing that the legality of EPT is somewhat inconclusive (*i.e.* potentially allowable) in twenty-seven jurisdictions, and likely prohibited in thirteen others, potential barriers to its national

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<sup>123</sup> ILL. ADMIN. CODE tit. 77 § 693.50(a)(3) (2008).

<sup>124</sup> *Id.*

<sup>125</sup> MICH. COMP. LAWS ANN. § 333.17751(1) (West 2008).

<sup>126</sup> Golden et al., *supra* note 16, at 113.

<sup>127</sup> See *Legal Status of Expedited Partner Therapy*, *supra* note 1.

<sup>128</sup> Golden et al., *supra* note 16, at 112.

<sup>129</sup> See *Legal Status of Expedited Partner Therapy*, *supra* note 1.



implementation must be addressed.

Accordingly, we proffer below a series of law and policy options designed to facilitate the national implementation of EPT to improve the public's health. These suggested policies include reforms to: (1) expressly endorse EPT through statutory or regulatory enactments, facilitated by the creation of model statutory language; (2) adopt modern, updated national treatment guidelines; (3) create exceptions to constrictive prescription drug requirements; (4) seek increased medical or pharmaceutical board support for EPT; and (5) support insurance payments for partners' medications provided through EPT.

***Create and enact laws that expressly endorse EPT.*** Although we conclude that the laws of 75% of the jurisdictions we studied permit or potentially allow the practice of EPT, an essential theme from our analysis is the presence of contradictory legal provisions and policy opinions in many jurisdictions. In Maine, for example, the Board of Licensure for Medicine has opined that dispensing medications to someone without having conducted a personal examination may constitute unprofessional conduct.<sup>130</sup> Still, Maine has incorporated by reference APHA's CCD Manual<sup>131</sup> and the CDC's *STD Treatment Guidelines*<sup>132</sup> for notifiable conditions, both of which may support EPT.<sup>133</sup> Consequently, health care providers may find themselves torn between adhering to a standard of care recommended by their state's disciplinary body and following the standard adopted (by reference) by the public health authority that may be in the best interests of their patients and the public's health. Facing the potential for sanctions or civil liability, even if remote, many health care providers will not practice EPT, as illustrated through the survey conducted by Golden and his colleagues.<sup>134</sup>

Statutes or other laws that explicitly allow EPT can empower health care providers to practice without fear of sanction, liability, or other harms. Effective legislation or regulation can also help define the scope of EPT by specifying applicable diseases, identifying health care practitioners who may prescribe medications, dismissing potential claims for civil liability, and expressly authorizing its use amidst ambiguous laws or policies. In addition to the four states that have enacted laws expressly

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<sup>130</sup> Maine Board of Licensure in Medicine, *Board Policy on Internet Prescribing*, (Nov. 12, 2002), available at [http://www.docboard.org/me/administrative/POLICIES/INTERNET\\_PRESCRIBING\\_SECTION\\_%20IV\\_GEN.doc](http://www.docboard.org/me/administrative/POLICIES/INTERNET_PRESCRIBING_SECTION_%20IV_GEN.doc).

<sup>131</sup> See AM. PUB. HEALTH ASS'N., *supra* note 87.

<sup>132</sup> See CDC *STD Disease Treatment Guidelines*, *supra* note 12.

<sup>133</sup> ME. REV. STAT. ANN. tit. 22 § 807 (2007).

<sup>134</sup> Golden, et al., *supra* note 16, at 114.

endorsing or supporting EPT,<sup>135</sup> other jurisdictions including New York,<sup>136</sup> Wisconsin,<sup>137</sup> and Massachusetts<sup>138</sup> have recently introduced related bills. Additional legislative activity may be stimulated by the production of model statutory language supporting the practice of EPT. The *Center* and CDC are currently exploring a project to develop model language that explains and authorizes the public health practice of EPT and simultaneously attempts to resolve existing legal conflicts in those jurisdictions whose legislatures or regulatory bodies may voluntarily choose to consider and enact the model.

***Adopt modern, updated national treatment guidelines.*** As noted, many states incorporate by reference the treatment guidelines set forth by CDC and/or the APHA. Advances in epidemiological science and public health practice, such as EPT, are reflected in CDC's 2006 edition of its guidelines, but states' regulations may refer to outdated editions of the guidelines and thus fail to incorporate the revisions in subsequent versions. For example, the District of Columbia incorporates by reference the Ninth edition of APHA's manual, published in 1960, and states that meeting its requirements (which are now forty-seven years old) is *prima facie* evidence of good medical or public health practice.<sup>139</sup> The 1960 version of the APHA manual could not possibly include more modern public health interventions like EPT. By contrast, Nevada incorporates the latest editions of APHA's manual and CDC's *STD Treatment Guidelines* automatically, stating, "[A]ny revision to the above guidelines is effective 10 days after its revision unless the state health officer files an objection with the state board of health."<sup>140</sup> As Nevada did, states should incorporate current versions of the guidelines through automatic adoption to keep abreast of the latest developments in public health, including the practice of EPT. Moreover, in states in which the public health authority can designate the appropriate treatment guidelines for STDs in keeping with recognized epidemiologic developments, the public health authority should explicitly endorse EPT as an acceptable treatment practice for gonorrhea and chlamydia.

***Create exceptions to existing prescription requirements.*** As discussed in Part III, prescription requirements can challenge the implementation of EPT by requiring patient identifying information on prescription labels and prohibiting the dispensation of drugs to individuals whom the physician has not examined. The laws of

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<sup>135</sup> See *supra* note 105.

<sup>136</sup> Assemb. 8730, 230<sup>th</sup> Legis. Sess. (N.Y. 2007).

<sup>137</sup> Assemb. 318, 98<sup>th</sup> Legis. Sess. (Wis. 2007).

<sup>138</sup> S 650, 183<sup>rd</sup> Sess. (Ma. 2003).

<sup>139</sup> D.C. MUN. REG. tit. 22 § 202.8 (2007).

<sup>140</sup> NEV. ADMIN. CODE § 441A.200(1)(d), (f) (2007).

thirty-eight jurisdictions require that prescription labels contain patient identifying information (e.g., patient name and address).<sup>141</sup> These laws may require that the medication's recipient or ultimate user—whether a patient or third party—be identified on the label prior to dispensation. In the context of EPT, requiring this information could undermine the recipient's anonymity and deter its practice. Regulatory exceptions to prescription label requirements may facilitate EPT in practice by allowing clinicians to provide “blank” prescriptions or an “extra dose” for the patient to deliver to the partner for the treatment of STDs like chlamydia or gonorrhea.

Providing access to prescription medications for public health purposes to persons whom a clinician has neither examined nor established a professional relationship with may seem counterintuitive and inconsistent with sound medical practice. A basic tenet of health care services in the United States is that clinicians should not provide prescription medications to non-patients. There are, however, exceptions to the basic rule. Physicians regularly give prescription medications to minor, elderly, or mentally-disabled patients through parents, spouses, caregivers, or court-appointed guardians.<sup>142</sup> Each year, public health practitioners provide flu vaccines without significant clinical evaluation to individuals who request it.<sup>143</sup> After outbreaks of meningococcal meningitis are detected in hospitals, hospital workers are given antibiotics for them and their family members without advance clinical diagnosis.<sup>144</sup> Although these examples differ from EPT, they each are designed to ensure that safe, effective medications are delivered to persons who need them, even without direct medical evaluation of the recipients.

In addition to labeling requirements, thirteen jurisdictions statutorily prohibit pharmacists from dispensing medications to individuals (1) who have not undergone a physical examination, (2) who have failed to establish a physician-patient relationship, or (3) who are not the ultimate user (*i.e.* a third-party is the ultimate user) pursuant to a valid prescription.<sup>145</sup> Since a patient's sexual partner would invariably fall within one of

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<sup>141</sup> See *Legal Status of Expedited Partner Therapy*, *supra* note 1.

<sup>142</sup> Peter S. Arno, et al., *The Economic Value of Informal Caregiving*, HEALTH AFFAIRS March-Apr. 1999, at 182-88; Am. Med. Ass'n., *Health Risks: Issues and Risks in Caregiving*, available at <http://www.ama-assn.org/ama/pub/category/8802.html> (last visited Apr. 1, 2008).

<sup>143</sup> Tricia Bishop, *Pupils to get Free Flumist: State Will Dispense 250,000 Doses of MedImmune Vaccine*, BALTIMORE SUN, Sept. 14, 2006, at 1D.

<sup>144</sup> Hodge et al., *supra* note 1.

<sup>145</sup> *Id.*; see, e.g., ARK. CODE ANN. § 17-92-505 (2008); FLA. STAT. § 465.023 (2007); HAW. REV. STAT. § 328-16(b)(3) (2007); KAN. STAT. ANN. § 65-1626(g) (2006); 247 MASS. CODE REGS. 2.00 (2008); MICH. COMP. LAWS ANN. § 333.17751 (2008); OHIO ADMIN. CODE 4729:5-30(A) (2007); OKLA. ADMIN. CODE § 535:15-3-13(d) (2006); S.C. CODE ANN. § 40-43-86 (2006); TEX. OCC.

these categories, pharmacists may be legally prohibited from dispensing medications to patients if the pharmacists are aware that an intended dosage is for their patients' sexual partners. While helping to protect the public from unscrupulous acts of various individuals, these prescription requirements should be reconsidered and reformed to allow EPT in consideration of the greater public health benefits that stem from EPT.

***Seek endorsements from medical boards.*** Most jurisdictions' laws do not specify whether issuing a prescription without prior medical evaluation or outside the physician-patient relationship is a per se instance of physician misconduct. Whether such practices are generally barred as unprofessional may be left to the discretion of medical or pharmaceutical licensing authorities. The *Center's* findings suggested that fewer than half (48%) of the fifty-two assessed jurisdictions featured any opinions (including Attorney General opinions) on EPT or like practices.<sup>146</sup> Of the twenty-five states in which boards issued opinions, sixteen (64%) prohibited EPT or like practices.<sup>147</sup> Opinions in nine (36%) states were more supportive.<sup>148</sup> In August 2006, for example, the New Mexico Medical Board voted to amend the state's Medical Practice Act to support EPT.<sup>149</sup> On a national level, the American Medical Association has directly endorsed the practice of EPT as applied to chlamydia and gonorrhea.<sup>150</sup> Additional medical and pharmaceutical board opinions consistent with this national trend would help resolve legal uncertainties concerning its practice even in states that seek statutory or regulatory amendments.

***Support insurance reimbursements for STD treatments for patients and partners.*** While legal issues are the focus of this article, economic factors also have the potential to complicate the practice of EPT. Questions may arise, for example, as to who should front the costs of an extra dose of antibiotics for the sexual partners of patients seeking treatment for chlamydia or gonorrhea. Who should pay – the patient, the partner, or perhaps public health authorities? When patients, partners, or public health authorities do not pay out-of-pocket for the prescription medications, should the

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CODE ANN. § 291.104 (2007); W. VA. CODE § 30-5-3 (2007).

<sup>146</sup> See *Legal Status of Expedited Partner Therapy*, *supra* note 1.

<sup>147</sup> *Id.*

<sup>148</sup> *Id.*

<sup>149</sup> N.M. Med. Soc'y., *Resolution B-204*, available at [http://www.nmms.org/subpages/NMMS\\_actionMeet.htm](http://www.nmms.org/subpages/NMMS_actionMeet.htm) (last visited Apr. 1, 2008).

<sup>150</sup> Am. Med. Ass'n, *Policy D-440.968, Expedited Partner Therapy (Partner-Delivered Partner Therapy)*, available at [http://www.ama-assn.org/apps/pf\\_new/pf\\_online?f\\_n=browse&doc=policyfiles/DIR/D-440.968.HTM](http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/DIR/D-440.968.HTM) (last visited Apr. 1, 2008); Council on Science and Public Health, *REPORT 7 (A-06)*, available at <http://www.ama-assn.org/ama/pub/category/16410.html> (last visited Apr. 1, 2008).

patient's health insurer cover the cost of two doses, even though the partner (who may or may not be insured by the same provider) is the recipient of the extra dose? How can the partner's health insurance company be expected to pay when the partner may not ever be formally diagnosed with an STD? Though costs for antibiotics to treat these STDs are typically low (depending on the form of medication),<sup>151</sup> the costs are compounded within a health insurance company that may be insuring hundreds or even thousands of patients involved in EPT. Health insurance providers may (1) seek to deny payment to the patient for the partner's "half" purely on the basis of cost savings and (2) allege that patients have engaged in insurance fraud by attempting to receive payments for drugs for which they are not the ultimate user.

Denying payment for these medications actually runs counter to the medical interests of the patient and partner for two primary reasons. First, the treatment of the patient's partner with STDs is directly tied to improving the health of the patient (which the provider is supposed to insure). Treating the partner may be the surest way to break the cycle of STD transmission. Absent effective treatment for the patient and partner, the patient likely will be infected again. Second, only through the preventive treatment of STDs like chlamydia and gonorrhea may more significant medical complications, addressed in Part II, be averted. Just as with many public health preventive measures, spending a small amount of money initially to prevent the spread of a disease or treat it early ultimately saves significant health care resources. Health insurers seeking to save dollars by denying payment for the extra dose of inexpensive antibiotics to partners may increasingly face the much greater costs of treating the long-term morbidity of patients with STDs. Accordingly, laws and policies should support a health insurance provider's payment for the patient's minimal expenses in delivering medications to partners through EPT. This recommendation would not, of course, obligate a patient's health insurer to pay the costs of any additional treatment for the partner.

## Conclusion

Increasing rates of STD infections like chlamydia and gonorrhea in the United States, diminishing public health resources, and low efficacy of traditional partner management practices present significant public health challenges. In the face of these challenges, public health authorities have crafted new strategies to limit the spread of STDs. By combining patient-based partner notification with medical treatment and education for partners, EPT is a promising new approach for treating some STDs and effectively breaking cycles of transmission among some patients. Given the paucity of

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<sup>151</sup> Hodge, et al., *supra* note 1.

available public health resources nationally, EPT is both epidemiologically and economically viable.

Yet the practice of EPT must confront barriers to succeed. Health care practitioners, patients, and partners question the practice on the basis of perceived legal impediments. Perceptions of illegality of EPT do not necessarily match reality. The *Center's* and CDC's legal assessment suggests that laws in most jurisdictions either expressly permit EPT or potentially allow it. Still, additional changes in law or its interpretation may enhance the practice of EPT in many jurisdictions. Law- and policy-makers should consider expressly adopting EPT via statutory or regulatory routes. Pharmaceutical laws that may hinder EPT in practice should be reconsidered. Medical and pharmaceutical boards should opine as to the legality or ethicality of EPT in their jurisdictions. Insurance laws underlying the payment of patient claims should support EPT. Together, these recommendations may help improve the legal environment for the modern practice of EPT to the improvement of the public's health.

