



# PHARMACIST-PRESCRIBED BIRTH CONTROL: THE EVIDENCE ON OUTCOMES

December 2020

## INTRODUCTION

Over the last several years, more and more states have begun allowing pharmacists to prescribe hormonal birth control methods like the pill. This model of access, commonly called the pharmacy access model, has received [bipartisan support](#) from [state lawmakers](#) because of its unique intentions to deliver on several important policy outcomes. It lowers the barriers to obtaining birth control, enables highly trained pharmacists to practice at the top of their abilities and reduces state spending on public health insurance programs.

For these reasons, the pharmacy access model has increased in popularity as a reform measure, with the hope that the intended benefits would materialize. As with all public policy, these intentions are important, but outcomes are what ultimately matter. As evidence emerges on the pharmacy access model, it is important to examine if it is producing its promised results.

## INTENDED VS. ACTUAL OUTCOMES

The pharmacy access model is meant to lower barriers to birth control on several fronts. First, it is intended to increase access to birth control by increasing the number of prescribing providers that women can see. With pharmacists serving as an access point, patients now have a wider array of providers they can visit for a prescription. Second, pharmacist-prescribing is intended to reach a demographic of [would-be birth control users](#) who find the overall cost of regular doctor's visits to maintain a birth control prescription too high—uninsured, low-income and public health insurance recipients all fit within this definition. Pharmacist-prescribing would increase overall access—but would especially reach these demographics. Finally, if pharmacist-prescribed birth control increases the number of birth control users, unintended pregnancy rates would decrease, and ultimately public health insurance programs would save taxpayer money in the long run.

## EMERGING EVIDENCE

*The pharmacy access model has led to thousands of pharmacies offering birth control consultations, meaning there are many new prescribers available to patients.*

As more states have begun to allow pharmacists to prescribe birth control, the number of prescribing pharmacists across the country has grown. In the 11 states and Washington, D.C. (out of 16 states that employ the pharmacy access model) that have data available, [over 3,300 pharmacies](#) have pharmacists available for birth control consultations. In Utah, for example, there are nearly [300 pharmacies](#) offering this service.

Indeed, incentivizing more pharmacists to prescribe depends on several factors: being able to bill insurance for consultations, prescribing to patients without being held to age restrictions (like only patients 18+ in some states) and the cost of complying with these new regulations all affect whether a pharmacy wants to offer this new service. States can ensure more pharmacists want to prescribe by [following best practices](#). Further, the current number of pharmacists prescribing is leading to notable access improvement, which is explored in the following section.

*The pharmacy access model has led to more women accessing birth control, including uninsured and younger women.*

Research using data from Oregon's Medicaid program shows that, of all new birth control prescriptions written for Medicaid recipients soon after Oregon's pharmacy access model was implemented, [10 percent](#) of them came from pharmacists. Additionally, research has found that women who see a pharmacist for birth control are [younger, less educated and less likely to be insured](#) than those seeing a physician for their prescription, meaning that they find the pharmacy access model less costly and easier to access. Pharmacists were also more likely than physicians to dispense [more than six months](#) of a birth control prescription at one time, meaning women are less likely to experience gaps in their birth control regimen. This is crucial for [avoiding unintended pregnancy](#).

*State health insurance programs save money on pregnancy-related health care costs.*

Many state lawmakers consistently seek to lower the taxpayer-funded costs of public health insurance programs like Medicaid. A substantial cost to these programs is pregnancy-related care, particularly for unintended pregnancies; in 2010, public insurance programs covered the health care costs associated with [68 percent of unplanned births](#) that year, totaling [\\$21 billion](#) in costs to taxpayers across the country. Early data on the pharmacy access model shows cost savings to state insurance programs. In Oregon, [research found](#) that the first two years of pharmacists prescribing led directly to fewer unintended pregnancies and a [\\$2 million reduction](#) in the associated publicly funded health care costs.

## CONCLUSION

Examining the early evidence on the pharmacy access model shows promising results that match the intended outcomes. Legislators seeking ways to increase birth control access and improve public health outcomes, while also reducing state-funded health care costs, should consider allowing pharmacists to prescribe birth control. This model is likely to only increase in its payoff for individuals, families and state budgets.

## CONTACT US

For more information on this subject, contact the R Street Institute, 1212 New York Ave. NW, Washington, D.C. 20005, 202-525-5717.

Courtney Joslin  
Resident Fellow  
Commercial Freedom  
[cjoslin@rstreet.org](mailto:cjoslin@rstreet.org)