



Best Practices, Barriers, and Benefits to De-Bundling Immediate Postpartum Long Acting Reversible Contraception Care

Introduction

In a time of increasing restrictions on reproductive freedom, and with the looming threat of the end of legal abortion at the federal level, long-acting reversible contraception (LARC) methods are increasingly appealing to patients and clinicians alike. LARC is extremely effective at preventing pregnancy, and many people opt for it to be inserted immediately following childbirth (immediate postpartum LARC or IPP LARC). While these methods have been commonly used among those who already have children, LARC is gaining popularity among young, childless people.

Patients are not the only ones seeking to avert unintended pregnancy — it's a national public health goal.¹ IPP LARC provision has been endorsed by the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Family Physicians, the Centers for Disease Control and the Centers for Medicare and Medicaid.² Widespread use of LARC, especially in the immediate postpartum period, is key to preventing unintended pregnancy, and the financial benefits to the patient, state, and insurer are undeniable.

This white paper will examine the best public health practices, the most significant barriers to access, and benefits to debundling of IPP LARC in the state of Massachusetts.

Background

Presently, there are three forms of contraception that fall into the LARC category: two types of intrauterine devices, or IUDs (copper and hormonal), which are inserted into the uterus, and the hormonal contraceptive implant which is implanted in the upper arm.³ These methods are 99% effective for 10, 5, and 3 years, respectively. IUDs provide the highest pregnancy prevention rate of any form of contraception.^{4,5} A medical professional is required to insert and remove these devices but there is no required maintenance during the period of efficacy, which enables the patient to live their lives without worrying about preventing pregnancy. This makes

¹ Centers for Disease Control and Prevention. (2015). Evidence Summary: Prevent Unintended Pregnancy. Retrieved from <https://www.cdc.gov/sixteen/docs/6-18-evidence-summary-pregnancy.pdf>

² Reddy, R. (2018). Mass. Should Make It Easier For Moms To Get IUDs Right After Giving Birth. WBUR, CommonHealth. Retrieved from <http://www.wbur.org/commonhealth/2018/07/23/birth-control-post-delivery>

³ Planned Parenthood Columbia Willamette. (2018). Long-Acting Reversible Contraceptives (LARCs). Retrieved from <https://www.plannedparenthood.org/planned-parenthood-columbia-willamette/long-acting-reversible-contraceptives-larcs>

⁴ Ibid.

⁵ Planned Parenthood. (2018). Birth Control. Retrieved from <https://www.plannedparenthood.org/learn/birth-control>



LARC especially appealing to those who have just given birth and wish to prevent pregnancy for the foreseeable future. LARC can be removed at any point by a medical professional when and if a patient decides it is time to grow their family.

Best Practices in Public Health

Ideally, the conversation between a patient and a provider regarding postpartum contraception takes place during prenatal visits. Such a consultation should cover the advantages, risks, contraindications and alternatives to each method of contraception, including LARC, so the patient is empowered to make an informed decision.

LARC is safe for placement at any point during the patient's stay in the postpartum unit before hospital discharge, including in the delivery room. According to ACOG, best practice for IUD insertion is while the patient is still in the delivery room, within 10 minutes of placental delivery in vaginal and cesarean births, when possible.⁶ Both of these contraceptive methods can be placed at a later time at no added risk to the patient, but to eliminate the risk of short-interval pregnancy, LARC should be placed before the patient is discharged.⁷ It should be noted that, although higher IUD expulsion rates have been associated with immediate postpartum insertion, as opposed to insertion at 4-8 weeks after delivery at a postpartum visit, patients were more likely to have continued using their IUD 6-12 months following immediate postpartum insertion.⁸

A patient who has not had the opportunity to select a postpartum contraception method prior to giving birth will likely not have another opportunity until their first, routine postpartum appointment, six weeks after childbirth. According to ACOG, 40-57% of women report engaging in unprotected sex in this six-week period.⁹ Unless breastfeeding consistently (every 4-5 hours), women who engage in unprotected sex during this period are at risk of a short-interval pregnancy (defined as timing of less than 12 months between last live birth and next pregnancy). Short-interval pregnancies are associated with worse perinatal outcomes including preterm birth, low birthweight, and infant death.¹⁰ In the first year postpartum at least 70% of pregnancies are unintended and all would fall into the short-interval classification. As with most health disparities, age, race, and socioeconomic status can increase risks for poor perinatal outcomes. According to the Massachusetts Department of Public Health, in 2014, 13% of births

⁶ The American College of Obstetricians and Gynecologists. (2016). Committee Opinion: Immediate Postpartum Long-Acting Reversible Contraception. Retrieved from <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Immediate-Postpartum-Long-Acting-Reversible-Contraception>

⁷ Ibid.

⁸ Goldthwaite & Shaw. (2015). Immediate postpartum provision of long-acting reversible contraception. Current Opinion in Obstetrics and Gynecology.

⁹ Ibid.

¹⁰ Conde-Agudelo et al. (2006). Birth spacing and risk of adverse perinatal outcomes: a meta-analysis. Journal of the American Medical Association.



to 15-19 year-olds were to women who already had one or more babies, indicating that adolescents are uniquely vulnerable to short-interval pregnancy.

For some patients, there is an even longer interval between delivery and their next doctor's appointment — only 70% of new mothers with MassHealth coverage had a postpartum visit in the 3-8 weeks after delivery although ACOG recommends a postpartum visit 6 weeks after birth.¹¹ This is due in part to the fact that most patients are insured at the time of delivery, and their insurance status is subject to change once the baby is born and the patient is no longer pregnant. Attending this visit significantly increases likelihood that a patient will use contraception, particularly LARC.¹²

These factors — both the risk of short-interval pregnancy and the potential lack of patient follow-up — make clear the importance for the patient to be informed of the full range of contraception options, so they may begin using their chosen method as soon as possible postpartum. The convenience of LARC insertion in the immediate postpartum period, and the high efficacy of LARC, make it an ideal contraception method for many patients. Offering IPP LARC during the delivery hospitalization is key in pursuing the public health strategy of reducing unintended pregnancy.

Though this paper has thus far articulated the many reasons why IPP LARC is an ideal form of contraception for patients who have just given birth, it is crucial to note that LARC, as with any form of contraception, can only be ideal for the patient if they have chosen the method themselves. The prenatal consultation, and the less favorable postpartum consultation, are vital opportunities for the patient to become fully informed of their contraception options. Though many patients may be drawn to it, there will inevitably be those who choose a different method, or no method at all. So long as the patient is acting without coercion, they are expressing their reproductive autonomy regardless of their choice.¹³ To insert an IPP LARC without the patient's consent, or to pressure the patient into having one inserted, would violate the reproductive autonomy of the patient.

IPP LARC Access in Massachusetts

One of the most common and detrimental barriers to IPP LARC access in Massachusetts is reimbursement policies that do not cover hospital and provider costs of

¹¹ MassHealth Office of Clinical Affairs. (2014). Managed Care HEDIS 2014 Report. Retrieved from https://www.mass.gov/files/documents/2017/11/13/hedis-2014_0.pdf

¹² American College of Obstetricians and Gynecologists. (2018). ACOG Redesigns Postpartum Care. Retrieved from <https://www.acog.org/About-ACOG/News-Room/News-Releases/2018/ACOG-Redesigns-Postpartum-Care>

¹³ Hastings Center Report. (2017). Reproductive Autonomy: Rights and Access for All. Retrieved from <https://onlinelibrary.wiley.com/doi/full/10.1002/hast.789>



insertion, such that providers do not offer this valuable care to their patients.¹⁴ LARC devices are among the most expensive methods of pregnancy prevention (\$400-\$1,000 for the devices and insertion), and health facilities will not provide LARC immediately following childbirth without reimbursement from insurers.¹⁵ Additionally, the way that labor and delivery services are bundled for insurance reimbursement often means that hospitals would lose money to cover the cost of LARC insertion.¹⁶ When insurers pay a bundled fee for the entire postpartum period, that fee to hospitals rarely covers the high costs of the LARC device and insertion. This is the case with most state Medicaid programs despite the fact that, in 2016, the Centers for Medicare & Medicaid Service advised that bundling the Diagnosis Related Group (DRG) code for labor and delivery services delays and can deter LARC use in the immediate postpartum setting.¹⁷

In the spring of 2018, MassHealth debundled the DRG and now reimburses separately for IPP LARC in its labor and delivery services reimbursement coding.¹⁸ A survey of the Massachusetts Association of Health Plans (MAHP), which represents 16 health plans covering more than 2.6 million Massachusetts residents, found that most of its members provide reimbursement for IPP LARC. Only two of MAHP's 16 health plans bundle immediate postpartum LARC with delivery. All of the MAHP plans that have MCO or ACO membership follow the MassHealth guidelines for MassHealth products, and unbundle the delivery reimbursement type which eases IPP LARC access.

Why Insurance Companies Should Debundle

The most straightforward solution to reducing barriers to IPP LARC access is for all insurance companies to debundle IPP LARC insertion from other labor and delivery services and care. Hospitals will only provide this essential service if they know they will get paid for it, and the bundled model simply does not cover the costs of IPP LARC care. This unfortunate reality translates to countless patients being denied access to extremely effective contraception they want at the time when they are most likely to continue using it to prevent unintended pregnancy.

¹⁴ American College of Obstetricians and Gynecologists. (2013). Medicaid Reimbursement for Immediate Post-Partum LARC. Retrieved from

<https://www.acog.org/~media/Departments/LARC/HMAPostpartumReimbursmentResource.pdf>

¹⁵ Planned Parenthood. (2018). Birth Control. Retrieved from

<https://www.plannedparenthood.org/learn/birth-control>

¹⁶ Reddy, R. (2018). Mass. Should Make It Easier For Moms To Get IUDs Right After Giving Birth.

WBUR, CommonHealth. Retrieved from <http://www.wbur.org/commonhealth/2018/07/23/birth-control-post-delivery>

¹⁷ Centers for Medicare and Medicaid Services. (2016). Re: Medicaid Family Planning Services and Supplies. Retrieved from <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf>

¹⁸ Massachusetts Executive Office of Health and Human Services, Office of Medicaid. (2017). Notice of Final Agency Action. Retrieved from <https://www.mass.gov/files/documents/2018/01/03/ry2018-acute-hospital-notice-of-final-agency-action.pdf>



Increased accessibility and affordability of IPP LARC also makes good public health sense. Individuals and their families are economically empowered when unintended pregnancies are averted. The state benefits as well: a 2014 Colorado study on IPP LARC use by teen mothers projected that the state would save \$6.50 for every dollar invested at three years.¹⁹

In addition to increasing affordability and accessibility of IPP LARC for patients and preventing unintended pregnancies, there are benefits to insurance companies. In 2015, a study published in *Fertility and Sterility* found that LARC, on average, can save insurance companies \$3,200 per pregnancy averted.²⁰ Pregnancy-related care and birth services are far more costly to an insurer than IPP LARC care.

Conclusion

Preventing unintended pregnancy is a state, national, and international public health goal. Pregnant patients have a unique opportunity to discuss family planning with their healthcare provider, in a moment in their lives when they are most likely to be insured. Choosing a postpartum family planning method should be the most difficult part of this process. Instead, a patient leaving this consultation fully informed and having chosen an IPP LARC as their desired method can face a significant barrier to accessing that method based on how their insurance covers this care. If appropriate and in the best interest of the patient, receiving IPP LARC before discharge will significantly decrease the likelihood of an unwanted pregnancy. But, if the hospital knows that they won't be adequately reimbursed for the cost of the device and insertion, IPP LARC care will not be available and the patient will not receive their family planning method of choice.

Debundling is also in the insurance company's best interest -- the cost savings are undeniable. Massachusetts Medicaid programs already know this, and debundled IPP LARC services from the labor and delivery services package for MassHealth. All insurance companies should follow suit, making IPP LARC accessibility a reality for all Massachusetts residents who choose it.

¹⁹ Han et al. (2014). Preventing repeat pregnancy in adolescents: is immediate postpartum insertion of the contraceptive implant cost effective? *American Journal of Obstetrics and Gynecology*.

²⁰ Washington CI, Jamshidi R, Thung SF, Nayeri UA, Caughey AB, Werner EF. (2015). Timing of postpartum intrauterine device placement: a cost effectiveness analysis. *Fertility and Sterility*. Retrieved from [https://www.fertstert.org/article/S0015-0282\(14\)02209-2/fulltext](https://www.fertstert.org/article/S0015-0282(14)02209-2/fulltext)