

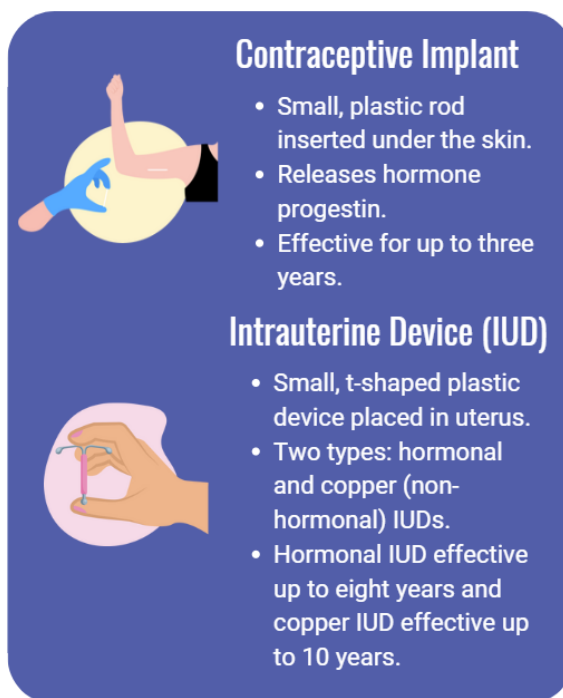
LONG-ACTING REVERSIBLE CONTRACEPTION

An Overview

Introduction

The ability to control fertility is essential to women’s health. Despite increasing access to contraception, however, the U.S. has persistently high rates of unintended pregnancies. In 2021, a quarter of U.S. pregnancies were unintended, and nearly a third of pregnancies in Arkansas were unintended.¹ The rate of short-interval pregnancies — pregnancies conceived within 18 months after a previous birth — is also high nationally, and these pregnancies are associated with poor maternal health outcomes. Nearly two-thirds of U.S. pregnancies beginning within the first year postpartum are estimated to be unintended.² Family planning is a critical tool to advance reproductive health, and a key component of family planning is long-acting reversible contraception (LARC, also used for “long-acting reversible contraceptive”), a method which offers long-lasting pregnancy prevention. This explainer covers how LARC works, evidence regarding its effectiveness, health plan coverage and reimbursement, and other policy issues.

FIGURE 1: TYPES OF LONG-ACTING REVERSIBLE CONTRACEPTION



Background

LARC methods include both intrauterine devices (IUDs) and contraceptive implants.

IUDs are small, t-shaped plastic devices placed in the uterus. There are two types of IUDs: hormonal IUDs, which release progestin (a synthetic version of the hormone progesterone) into the uterus, and copper IUDs, which do not include hormones. Hormonal IUDs are effective for three to eight years depending on the type used.³ Copper IUDs are effective upon insertion and last up to 10 years after placement. There is one U.S. Food and Drug Administration (FDA)-approved copper IUD (Paragard), and there are four FDA-approved hormonal IUDs (Mirena, Liletta, Kyleena, and Skyla). Hormonal IUDs work by thickening cervical mucus to prevent the entry of sperm and by thinning the lining of the uterus to prevent implantation. Copper IUDs prevent sperm from reaching and fertilizing an egg by producing an inflammatory reaction that is harmful to sperm.

IUD selection should be the result of shared decision-making between a patient and a doctor based on the patient's individual health needs and preferences.³ For example, one patient may prefer a copper IUD over a hormonal IUD because copper IUDs are longer-lasting. Another patient may prefer a hormonal IUD because hormonal IUDs are associated with less bleeding and are FDA-approved for girls and women with heavy cycles. For some, hormonal IUDs may cause menstrual cycles to cease altogether, although there is variation in individual menstrual cycle response, with some research suggesting that those with heavier menstrual cycles were less likely to experience amenorrhea (the absence of menstruation).⁴ Copper IUDs are typically associated with more regular cycles but often cause increased bleeding in the first six months of use. Individual patients may also have health conditions that limit their options (e.g., a copper allergy, thus requiring a hormonal IUD or other contraceptive option).⁵

Contraceptive implants are matchstick-sized plastic rods inserted under the skin in the upper arm that work by releasing progestin into the body, preventing pregnancy by preventing an egg from being released from an ovary and thickening cervical mucus to prevent sperm entry into the uterus. These implants are effective for up to three years before they require replacement.³

There is only one FDA-approved contraceptive implant on the market (Nexplanon). If a woman decides she wants to become pregnant, the devices can be removed by a medical provider.⁶

Importantly, LARCs — both IUDs and contraceptive implants — do not provide protection from sexually transmitted infections.

While LARCs should not be placed in pregnant women, they

are safe for use shortly after a woman gives birth and while a woman is breastfeeding.⁷ LARCs offer an effective intervention to reduce short-interval pregnancies. Despite their efficacy, the use of LARCs as postpartum contraception remains low in Arkansas, with fewer than 20% of recently pregnant women utilizing these methods in 2021 (see Figure 2).⁸

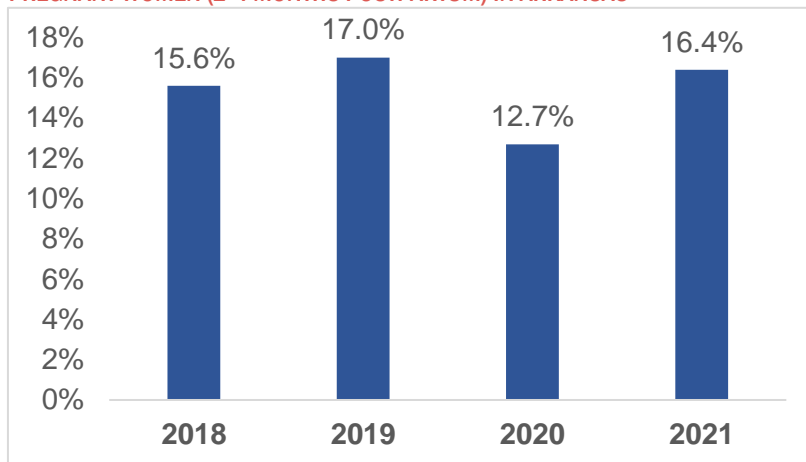
The American College of Obstetricians and Gynecologists has stated that contraceptive counseling is an important interaction between patients and their providers and should be patient-centered to help patients achieve their reproductive goals.⁹ The organization maintains that patient choice should be the principal factor in determining a method of contraception and supports contraceptive counseling that is non-coercive.

Evidence on Efficacy, Barriers, and Challenges

LARCs are the most effective form of reversible birth control available, with fewer than 1 in 100 women who use a LARC becoming pregnant within the first year of use. Over time, LARCs are 20 times more effective than other types of birth control, including oral contraceptive pills and birth control patches.⁵

Due to their effectiveness and long duration, LARCs are recommended as the first-line contraceptive choice for adolescents by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (ACOG). However, a 2018 study found that LARCs have low uptake — less than 5% — among sexually active adolescents.¹⁰

FIGURE 2: LONG-ACTING REVERSIBLE CONTRACEPTION USE AMONG RECENTLY PREGNANT WOMEN (2-4 MONTHS POSTPARTUM) IN ARKANSAS



A 2014 study examining the Contraceptive CHOICE Project (a large prospective cohort study designed to promote the use of LARCs in the St. Louis, Mo., area) found that of the more than 1,400 teenage girls and women enrolled in the program, 72% chose a LARC for birth control purposes and 28% selected another birth control method.¹¹ Among the program participants enrolled during the period of 2008 to 2013, pregnancy rates were 34 per 1,000 teens, birth rates were 19.4 per 1,000 teens, and the abortion rate was 9.7 per 1,000 teens. All were significantly lower than national rates of pregnancy (158.5 per 1,000 teens), birth (94 per 1,000 teens), and abortion (41.5 per 1,000 teens) experienced by sexually active teens in 2008.

There are numerous barriers that have limited uptake of LARCs. Among healthcare providers, barriers include a lack of on-site device availability, a shortage of providers trained to place or remove LARCs (particularly among primary care providers), and low reimbursement rates. Among patients, barriers include a lack of information about the safety and acceptability of LARCs, fear of potential side effects, and apprehension regarding pain during insertion.^{12,13} While ACOG cites pain with IUD insertion as a clinical challenge of long-acting reversible contraceptive methods and has reviewed various studies exploring pain management options, current guidelines do not explicitly recommend pain control during IUD placement.¹⁴

Coverage and Reimbursement

PRIVATE AND SELF-INSURED PAYERS

The Affordable Care Act requires most private plans to cover all FDA-approved contraceptive services and supplies without cost sharing.¹⁵ Studies have shown an increase in LARC insertion since implementation of the ACA contraceptive coverage requirement.^{16,17}

MEDICAID

Federal Medicaid law classifies family planning as a benefit that all state Medicaid programs must cover for all eligible beneficiaries¹⁸ without cost sharing. While states have latitude in determining what specific services and supplies are included within this benefit, few impose utilization controls on the coverage of LARCs.¹⁹

Arkansas Medicaid provides coverage for both IUDs and contraceptive implants. For IUDs, Arkansas Medicaid reimburses providers for the LARC device and for LARC insertion, removal, and reinsertion, if requested.²⁰

Sufficient reimbursement for LARC placement within state Medicaid programs is an ongoing challenge. Within an outpatient setting, LARC devices often have a high up-front cost for providers, and insufficient payment rates create a disincentive for providers to obtain these devices. Some states also limit provider payment to the initial LARC placement without providing payment for replacement or reinsertion if medically necessary. Additionally, if LARCs are covered under the pharmacy benefit — as opposed to the medical benefit — and a LARC is not used by the patient the device is dispensed to, the provider may be unable to return the device and therefore will suffer additional financial loss.²¹

Other State Efforts

IMMEDIATE POSTPARTUM PLACEMENT OF LARCS

The “unbundling” of global delivery payments²² — i.e., providing separate Medicaid reimbursement for immediate postpartum placement of LARCs instead of bundling reimbursement for all obstetrical services together — is a policy option that many states have pursued. As of October 2023, 46 states and the District of Columbia had unbundled global delivery payments with separate reimbursement for immediate postpartum placement of LARC within their Medicaid programs.²³ Under a law passed by the Arkansas General Assembly in 2023, Arkansas Medicaid now provides separate reimbursement from the bundled delivery payment for LARC placement.²⁴ Most states, like Arkansas, provide separate payment for both the device and the insertion. Less optimally, a few states only provide separate reimbursement for the insertion (with the device part of the global delivery payment) or for the device (with the insertion part of the global delivery payment).¹⁹

Separate reimbursement for LARCs has been associated with increased uptake of these devices. A 2019 study assessing South Carolina Medicaid’s coverage for immediate postpartum LARC placement found that the state’s shift to separate reimbursement was associated with increases in LARC utilization and flattening of a previously increasing trend in short-interval births among adolescents.²⁵

Separate reimbursement for LARC placement by Medicaid has also been found to have broader impact on non-Medicaid beneficiaries. A study published in the Journal of the American Medical Association analyzing immediate postpartum LARC placement in five states (Georgia, Iowa, Maryland, New York, and Rhode Island) found that separate reimbursement for LARC

placement was associated with an increase in LARC use among commercially paid births in four of the states.²⁶

Immediate postpartum LARC placement has also been associated with reduced unintended and short-interval pregnancies among Medicaid beneficiaries.^{3,27} Studies have also examined use of LARCs for birth timing and their use to support intended pregnancies. One study estimated that 62% of women who discontinue LARC between the ages of 20 and 34 have a live birth within nine years following discontinuation and that 45% of those births result from intended pregnancies. Among women who did not have a live birth within nine years after discontinuing LARC, 18% had a new LARC inserted and 13% initiated contraceptive sterilization.²⁸

ACOG supports immediate postpartum LARC placement before hospital discharge as a best practice to prevent rapid repeat and unintended pregnancies. ACOG also notes that women should be counseled during prenatal visits about immediate postpartum LARC placement as an option, along with advantages and disadvantages of placement.²⁹

COMPLEMENTARY STATE INITIATIVES TO SUPPORT IMMEDIATE POSTPARTUM LARC UPTAKE

Tennessee adopted a Medicaid policy change to create separate reimbursement for LARC placement and launched a statewide initiative to support LARC uptake. The Tennessee Initiative for Perinatal Quality Care included provider/patient education, contraceptive counseling, and dedicated “LARC champions” assigned to hospitals. An evaluation of the project showed that in one year, more than 2,000 women received LARCs.³⁰

Virginia established the Virginia Postpartum LARC Workgroup, representing a network of agencies working collaboratively to reduce unintended pregnancies and increase access to quality family planning services. Following unbundling of Medicaid reimbursement for LARC, the workgroup developed a toolkit for providers on obtaining payment for LARCs.³¹

In New Mexico, the state utilized Medicaid administrative matching funds to develop a LARC mentoring program. The program provided statewide training on contraceptive counseling, provision of LARCs, LARC reimbursement, and shared decision-making. The program also provide training to Medicaid clinicians on LARCs and immediate postpartum placement.³²

CONCLUSION

LARCs are highly effective contraceptive methods shown to reduce unintended pregnancies, promote optimal pregnancy spacing intervals, and give women control over fertility. Both public and private insurers typically provide coverage for these devices, with states pursuing additional policy options to increase their use. Separate reimbursement for immediate postpartum placement of LARCs within state Medicaid programs has been associated with increased use. Many states have also pursued provider and patient engagement efforts to increase uptake. Importantly, individual decisions around contraception should never be coercive and should result from informed conversation with a trusted healthcare provider.

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