Center for American Progress

Helping More Women Access Long-Acting Reversible Contraceptives

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Contents

Introduction and summary

The United States has one of the highest unplanned pregnancy rates among developed countries.[1] Increasing access to contraception helps women plan whether and when to have children, resulting in healthier pregnancies and infants. For many women, the ideal time to start contraception may be immediately after a birth or an abortion. Within Medicaid, however, there are several policy barriers that prevent women from accessing highly effective methods of contraception—long-acting reversible contraception, or LARCs—at these times.

This report delves into why LARCs can be an excellent choice for women following birth and after receiving abortion care but also notes the need for both policymakers and providers to be aware of and sensitive to the history of contraceptive coercion in the United States, especially with regard to women of color. After reviewing general barriers to accessing LARCs postpartum and postabortion, this report offers specific examples of federal and state action and inaction on this matter. It concludes by offering needed legislative and regulatory state and federal policy solutions that should be implemented to improve access to LARCs for all women. Most of these changes can be implemented independent of any legislative action.

Postpartum recommendations:

- While many states have begun to improve LARC access, federal guidance directing how best to promote immediate postpartum placement should be issued to create a national standard.

- Independent of any federal action, states should ensure that providers will be reimbursed for providing LARCs postpartum.

Postabortion recommendations:

- End federal and state restrictions on funding for abortion care under Medicaid, such as the Hyde Amendment, which needlessly complicates the billing process for LARCs.

- Even without lifting funding prohibitions, federal and state guidance should be issued clarifying that LARCs can be provided postabortion without violating these prohibitions and how best to do so.

Training and education recommendations:

- Because of significant provider confusion on who is eligible for LARCs, federal and state training programs should be established to improve understanding.

The choice whether to use birth control of any type is a personal one, but these changes would help ensure that women have greater access to all of their options when making that decision.

The need for access to contraception

Access to reliable contraception is important for planning safe, healthy pregnancies and children, as well as reducing unintended pregnancies in the United States.[2] Because of a lack of access to affordable family-planning services, it is generally young women, women of color, and those who are low income and less educated who experience higher rates of unintended pregnancy and birth.[3] Four in 10 women of reproductive age have had an unintended pregnancy,[4] and many have repeat unintended pregnancies.[5] Data from the National Survey of Family Growth found that women who have already had at least one live birth make up 61 percent of unintended pregnancies and 75 percent of unwanted births.[6]

To help ensure all women can plan if and when to have children, any efforts to improve access to contraceptives should highlight the importance of increasing the availability of long-acting reversible contraception following a birth or an abortion.

LARCs: An important option

LARCs—which include intrauterine devices, or IUDs, and implants—are highly effective methods of nonpermanent contraception.[7]

Furthermore, LARCs are considered very safe for immediate placement both postpartum and postabortion. Immediate postpartum IUD placement, for example, is associated with lower expulsion rates than delayed placement.[8] And one study of IUD insertion postabortion showed that not only did women who chose immediate placement not experience another unintended pregnancy during the study, but they also did not present any more adverse conditions than the women who delayed contraceptives.[9]

Once in place, LARC methods are considered the most effective forms of reversible birth control available—20 times more effective than birth control pills.[10] One study specifically examined IUD placement immediately after cesarean delivery and found that more women were using an IUD at six months postpar-

tum—83 percent—compared with women who received an IUD six weeks after delivery—64 percent.[11] And another recent study showed that the repeat abortion incidence for women who received implants immediately postabortion was 3.8 percent at 24 months compared with 11.6 percent for those using shorter-acting methods such as oral contraceptives. At 48 months, only 6.6 percent of implant users experienced a subsequent abortion compared with 18.3 percent for those using short-acting methods.[12]

Recent studies have shown increases in the number of women who choose LARCs immediately postpartum and postabortion. This may be, at least in part, because LARCs typically have the highest patient satisfaction rates out of all birth control options.[13] Additionally, LARC usage significantly increased—from 0.4 percent in 2005 to 7.1 percent in 2013—among the 7.5 million teenagers ages 15 to 19 who seek contraceptive services from Title X-funded clinics.[14] LARC usage is also related to age: Research shows that the odds of a woman choosing a LARC postabortion—specifically, an implant—increase with decreasing age,[15] suggesting that younger women are likely to choose LARC methods when presented with the option.

Yet in spite of these increases, use of LARCs in the United States is still lower than that in most developed countries. In some European countries, LARC usage represents more than 30 percent of all contraceptive use, while only 10 percent of U.S women using contraceptives choose LARCs.[16]

Counseling and informed consent

Proper counseling can help ensure a woman is aware of all of her contraceptive options postpartum and postabortion and can exercise her reproductive rights in the way that is best for her. As with any medical procedure, informed consent must be the priority in any discussion on LARCs between a medical provider and patient.

Especially when discussing placement postpartum and postabortion, it is extremely important that providers are cognizant of the potential for coercion while seeking not to perpetuate damaging stereotypes about women of color, low-income women, and those living with disabilities that are an inseparable part of the history of forced sterilization and contraception coercion in the United States.[17] The decision to use contraception of any sort is a personal decision; by providing informative and supportive counseling, providers can help women make the best decision for themselves on which, if any, contraceptives to use.

When women receive postabortion contraceptive counseling that includes information about LARCs, many choose one of these highly effective methods.[18] Among a sample of postpartum women, 38 percent wanted to begin using an implant or IUD.[19] A survey of patient attitudes postabortion found that 67 percent of the patients wanted to leave the appointment with contraception, and 33 percent were interested in a LARC method.[20] Another survey found that more than one-third—37 percent—said they would use a LARC immediately upon pregnancy termination if the option was available to them.[21]

Even with the evidence of LARCs' effectiveness and increased use, however, the country still has policy barriers that delay or prevent some women from accessing IUDs and implants.

General barriers to LARC use postpartum and postabortion

The likelihood of receiving highly effective methods of contraception drops when there is a delay in access after a birth or an abortion.[22] Medicaid policy must be structured to allow a woman to get a LARC during the same visit as her delivery or abortion, if she so chooses. Unfortunately, several factors cause delays in a woman's ability to do this. While immediate LARC placement postpartum and postabortion is safe and effective, many providers still have misconceptions about LARCs that can keep patients from understanding all of their options. And billing practices, especially when paired with public funding restrictions on abortion care, can further complicate and restrict access.

Together, these barriers create unnecessary difficulties to providing highly effective contraceptive methods to women who could benefit greatly from beginning them postpartum or postabortion.

Billing practices for postpartum and postabortion care

Since 1972, federal law has required that all state Medicaid programs cover family-planning services and supplies without cost-sharing for enrolled individuals of reproductive age. But states have a great deal of flexibility in how these programs are administered and how providers are reimbursed.[23]

Generally, when covered by public or private insurance, birth and abortion care are billed under their respective codes—codes that frequently include a package of services. The high upfront cost of LARCs—which can be more than $700—makes it financially challenging for many medical professionals to provide these methods without guaranteed reimbursement.[24] In order to ensure reimbursement for LARCs, the expense for the contraceptive needs to be either built into these codes or billed separately at the time of placement.

For example, most insurers negotiate a single payment amount for births included in a Diagnosis-Related Group, or DRG, code that covers labor and delivery services, as well as postpartum care that varies based on type of delivery. DRGs are a system of classifying hospital cases. Using a DRG code can help simplify payments by providing hospitals with a lump-sum payment for labor and delivery.

But such a code does not typically allow facilities to bill separately for other procedures, drugs, or devices—such as LARCs—provided during the inpatient postpartum period, creating a barrier to receiving immediate postpartum insertion of these costly devices. If a DRG does not include LARC placement and there is not a separate billing code for that a provider can use to bill the LARC procedure outside of the DRG, reimbursement for placement may be hard to guarantee. For example, a DRG code may reimburse a hospital $4,000 for birth care. If a LARC is placed postdelivery and there is no separate billing procedure or it is not included in the global payment, the hospital cannot receive additional reimbursement for the LARC beyond the regular $4,000. As discussed later in this report, either adding the costs of LARCs into the code or exploring other strategies to obtain prompt reimbursement is a necessary part of improving access to LARCs.

There are other problems as well. For example, in some state Medicaid programs, a LARC must be ordered well in advance of placement in any situation, limiting a woman's ability to choose a LARC on the same day as a delivery or abortion.[25] And some states subject LARCs to prior authorization requirements—and, as the Centers for Medicare and Medicaid Services, or CMS, explains, "as part of the prior authorization process, [states and/or managed care organizations] may question the medical necessity absent failure using another birth control method."[26] This delays access and perhaps even results in denial of the device.

The impact of public funding restrictions on postabortion care

Further complicating matters, billing for LARCs becomes even more complex postabortion because of the many state and federal prohibitions on the use of public funds for abortion care. The federal government—through the long-standing Hyde Amendment—only allows federal funding to be used for abortion care in narrow circumstances.[27] In addition, 32 states follow the federal government's lead.[28] Congress also prohibits the District of Columbia from using its own revenue to provide abortion care for low-income residents.[29]

Even when abortion care can be billed to Medicaid, inviting the same complications as explained above, providers who seek to offer LARCs postabortion can face confusion stemming from strict federal and state policies that restrict Medicaid funding for abortion and create walls of separation between abortion care and family-planning services supported by federal funds.[30] As in many other contexts, these damaging restrictions limit both access to abortion and contraceptive care options.[31]

Although providers may seek payment for LARCs inserted postabortion without violating the law, there is a fear that doing so could bring serious legal consequences because of these widespread restrictions.[32] This perception problem extends past Medicaid as well.

For instance, clinic activities—such as LARC placement—that are reimbursed with funds from Title X, the federal grant program for family-planning services,[33] have to be separate from abortion care. Many states also put additional restrictions on their family-planning funds.[34] As with Medicaid, these separation policies reduce access to LARCs by creating confusion on how to handle reimbursement for contraception postabortion.

Similarly, the 340B Drug Pricing Program can be used by certain safety net providers to purchase LARC devices from manufacturers at a reduced price.[35] But because it is a federal program and there needs to be separation between federal funds and abortion services, many providers are wary of using these reduced-cost devices in any visit related to an abortion procedure—despite the fact that the discounts are provided by the manufacturer, not the federal government.[36]

The 340B Drug Pricing Program

The Health Resources and Services Administration created the federal 340B Drug Pricing Program in 1992[37] to provide facilities that treat a large number of uninsured and vulnerable people with discounted prescription outpatient drugs. Manufacturers participating in Medicaid must provide eligible health care facilities and covered entities with discounted drugs, reducing the costs for providers.[38] The discounts under the 340B program are provided by the manufacturer of the drug itself, not the federal government.[39]

Outpatient drugs eligible for the program include:

- Food and Drug Administration, or FDA, approved prescription drugs
- Prescribed over-the-counter drugs
- Prescribed biological products, excluding vaccines
- FDA-approved insulin[40]

Only nonprofit organizations with specific federal designations or funding are eligible for the program, including:

- Federally Qualified Health Centers
- Ryan White HIV/AIDS Program grantees
- Medicare/Medicaid Disproportionate Share Hospitals
- Children's hospitals
- Other safety net providers and specialized clinics[41]

Unfortunately, these misconceptions can have serious implications for access to LARCs postabortion. A survey of 173 specialized and broad-based facilities that provide abortion care revealed many challenges to incorporating contraceptive services into abortion care.[42] The specific challenges and their effects on abortion providers varied depending on the type of facility and the state Medicaid policy. An abortion facility is considered specialized if abortion care makes up more than half of its patient services. A majority of abortion procedures take place in these facilities, and in the survey, they were less likely to accept insurance for contraceptive services. This made LARC methods, which have high upfront costs, less available. When facilities did accept insurance for contraceptive services, they were more likely to have LARC methods and offer immediate placement after an abortion procedure.

Further demonstrating the damaging effects of restrictions on public funding, another major cause of variation was whether the facility was located in a state that accepts Medicaid for abortion care. At the time of the survey, 15 states allowed

state funding for all or most medically necessary abortions and almost half of the facilities sampled were in one of those states. Only 54 percent of facilities in states that could not accept Medicaid for abortion took insurance for contraception compared with 92 percent in Medicaid-accepting states.

Private insurance

While not the focus of this report, women with private insurance can also face barriers to accessing LARCs postpartum and postabortion. Private insurance is not exempt from the complex and sometimes confusing billing practices explained here that limit access to LARCs for women who receive their insurance through Medicaid. Perhaps even more concerning, a growing number of states have banned coverage of abortion in both private and public insurance plans,[43] leading to additional barriers. If federal and state governments improve their policies regarding LARC insertions, access would not only increase for a large number of women, but such policies also would signal to private insurers the need to, and how to, change contraceptive reimbursement.[44]

Education and training for providers

Providers would not only benefit from a better understanding of the reimbursement complexities for postabortion LARC placement because of funding restrictions. They also need a better understanding of the safety and benefits of LARCs generally.

Misconceptions exist even among family-planning professionals about IUDs and implants, especially with regard to providing IUDs to young women and women who have never given birth. Often, barriers to LARC access also are the result of a lack of knowledge among providers about the safety and efficacy of IUD insertion postpartum and postabortion.[45]

A 2014 study cited in a Kaiser Family Foundation report[46] found that less than half—46 percent—of the 1,150 OB-GYNs surveyed said an IUD could be placed immediately after birth.[47] Meanwhile, only one-fifth—20 percent—said IUDs could be inserted immediately postabortion,[48] and less than half believed IUDs were appropriate for teenagers.[49] Yet a recent study also shows that even a few hours of training can result in an increase in access.[50]

The scope of providers who receive training should not be restricted to OB-GYNs. As medical care providers for the majority of teenagers, primary care clinicians and pediatricians should also have proper training about LARCs.[51] All contraceptive methods are safe for teens, and one of the main advantages of LARC methods for this subgroup is that teenagers have a higher than typical failure rate for methods that are user dependent.[52] Although the rate of teen births has declined over the past few decades, it is still an area of concern because one in five unintended teen births is a repeat birth.[53] And these pregnancies among teen mothers also tend to have shorter interpregnancy intervals, which can lead to preterm births.[54] Postpartum LARC use could reduce the rate of repeat pregnancy and support healthy spacing of pregnancies.

Federal and state action on LARC access

Both the federal government and states have taken steps to improve access to LARCs postpartum, but too little attention has been paid to improving access to LARCs postabortion. At the same time, some states have begun to implement training programs to help providers become more aware of the benefits of LARCs and how to bill for them.

Postpartum

Improvements are being actively undertaken by both the federal government and states, but there is no set standard that could be considered a national benchmark.

Federal action

In 2014, the Centers for Medicare and Medicaid Services and the Children's Health Insurance Program, or CHIP, Maternal and Infant Health Initiative endorsed "timely and convenient access to LARCs" postpartum.[55] Key goals of the initiative are to reduce unintended pregnancy and increase the use of highly effective contraceptives.[56] LARCs are an important tool to accomplish these goals and to promote pregnancy planning and spacing. Recently, CMS highlighted state action to improve Medicaid billing for LARC services and noted the varying approaches currently being undertaken to achieve this goal.[57]

State action

At least 20 states—Alabama, California, Colorado, Connecticut, Delaware, Georgia, Illinois, Indiana, Iowa, Louisiana, Maryland, Missouri, Montana, New Mexico, New York, Ohio, Oklahoma, South Carolina, Texas, and Washington—and the District of Columbia have issued guidelines to improve Medicaid

reimbursement of LARC placement immediately after birth.[58] These changes are perhaps in part due to increasing awareness that Medicaid policy affects the majority of births in the United States. In 2010, Medicaid covered 51 percent of all births and 68 percent of health care related to unplanned births.[59] For example, the Georgia Department of Public Health altered its Medicaid reimbursement guidelines in 2014 because officials determined that postpartum LARCs could improve the morbidity and mortality of mothers and infants by promoting healthy spacing between pregnancies. These officials also hope to reduce the high rates of unintended teen pregnancy and repeat pregnancy in the Medicaid population.[60]

Many states are changing their Medicaid policies so that the cost of a LARC is bundled into the hospital's cost of delivery. This approach has found favor in a diverse set of states, including Alabama, Delaware, New York, and Texas.[61]

Other states have undertaken different approaches, such as raising payment rates to providers for all contraceptives, including LARCs, to incentivize providing the full range of methods; removing barriers to supply management of LARC devices—for example, addressing stocking and disposal costs; and removing administrative barriers such as preauthorization for provision of LARC visits and LARC procedures on the same day.[62]

Despite improvements, some state Medicaid policies continue to directly restrict access. In Missouri, for example, to receive reimbursement from Medicaid for LARCs, a provider has to order the device from a pharmacy in a patient's name. It can take several days for the device to arrive and, because it is ordered for a specific patient, if the patient does not return for placement, the device cannot be used for anyone else.[63] If the patient knows she wants a LARC method prior to birth or obtaining abortion care, the device can be ordered in advance and possibly arrive in time for immediate placement after birth or the abortion procedure. However, women often select contraceptive methods after the procedure and then do not return for the LARC insertion after the device has been ordered. This policy is meant to protect Medicaid and providers from paying for high-cost LARC devices upfront, but it restricts options for same-day comprehensive contraceptive care and is inefficient for providers and patients.[64]

Illinois previously had a pharmacy system for ordering LARC devices that was similar to Missouri's, but the state changed its procedure after realizing it was losing money from patients who never had their device inserted.[65] Thus, the Illinois

Department of Healthcare and Family Services changed the procedure to buy and bill: The provider buys the device and then bills the insurer once it has been inserted. In addition, a 2014 family-planning action plan outlined initiatives to alleviate providers' financial concerns.[66]

Postabortion

Even in states where abortion care is covered under Medicaid programs, billing challenges similar to those described in the postpartum context are likely to arise for postabortion care as well. Furthermore, no federal or state initiative has focused on improving access to LARCs postabortion in the same way as for postpartum care. Yet privately funded programs have shown how effective such programs can be. And unfortunately, even when states do not restrict abortion care coverage, provider concern over federal prohibitions remain.

Privately funded state programs

While filling an important void, the privately funded programs that provide LARCs to women postabortion are not a solution across the county. They do, however, demonstrate how helpful expanded access could be for women.

A New York City pilot study examined the difference in outcomes for women who had immediate access to contraceptives after abortion compared with those who faced delays.[67] Researchers followed two groups of Medicaid-eligible women for a year after having a first trimester abortion. One group received comprehensive contraceptive care, including LARC placement or Depo-Provera injections, during their abortion visit, while the other group had to come back for an additional visit to get an IUD, implant, or injection. Neither group had to pay for their contraception, but the group that had immediate access saw an increase in LARC use—46 percent versus 11 percent—and a decrease in repeat pregnancies. These one-year results are positive and telling, and the researchers expect these trends to continue beyond the observed period because LARC methods remain effective for 3 years to 10 years.[68]

Another effort to promote LARCs includes the Contraceptive CHOICE Project through the Washington University in St. Louis and an anonymous foundation.[69] The project studied the use of LARCs and their effects on the rate of unintended pregnancies in the area. Women seeking abortion care were a special popula-

tion studied in the program and were recruited at area facilities where abortions are provided.[70] In the project, 3,410 women with a recent history of abortion received no-cost contraception, with 937 receiving contraception on the same day as the abortion procedure.[71] Women with a recent history of abortion were more likely to have a history of repeat unintended pregnancies and were more likely to choose a LARC method—84.5 percent versus 72.9 percent.[72] Additionally, women with the immediate placement option after an abortion had high continuation rates that were similar to those that did not have immediate placement—81.5 percent versus 82.8 percent.[73]

Colorado Family Planning Initiative

The Colorado Family Planning Initiative gained national attention for making IUDs and implants more accessible to low income and uninsured women.[74] The Colorado Department of Public Health and Environment reports that since 2008, more than 30,000 women have been able to choose a LARC method because of the program.[75] There has been a particular focus on providing effective contraceptives to teen mothers, and the state found that the vast majority of teen mothers who received a postpartum LARC did not have another pregnancy within two years.[76] The state rates of unintended pregnancy, repeat pregnancy, and abortion have all declined, which has also resulted in Medicaid savings.[77]

The original grant funding ended at the start of July 2015. Several organizations and foundations, however, pledged $2 million to keep the program solvent, and the state's fiscal year 2017 budget increased investment in family-planning services, recognizing the success of the program.[78]

State abortion restrictions' relationships to LARCs

As noted above, unlike Medicaid solutions to postpartum LARC access, postabortion access to LARCs is affected by state abortion laws and restrictions.

Missouri

Missouri's extensive abortion restrictions create significant barriers to access to abortion care for women, including a 72-hour waiting period between abortion counseling and the actual procedure and very limited insurance coverage of abortion.[79] Together, these policies have a unique impact on the availability of LARC methods postabortion.

In Missouri, both public and private insurance cover abortion only in limited cases: life endangerment of the mother for private coverage—unless a separate rider is purchased—and life endangerment, rape, and incest for public coverage.[80] While this creates a financial burden for most women seeking an abortion by forcing them to pay out of pocket for the procedure, this prohibition can simplify the billing procedure for LARCs. Because the abortion procedure cannot be billed to insurance in most cases, normal—as in entirely separate, as if the abortion did not occur—billing procedures for LARCs can be followed for women with private contraceptive coverage, allowing the patient to get a LARC immediately postabortion. Medicaid and Title X funds can also be used the same day for women without health insurance to reduce the cost of the device and procedure. Thus, for states with these unfortunate insurance restriction policies, there is at least the opportunity to provide comprehensive contraceptive care on the same day as an abortion. At the same time, the provider and patient still must adhere to Missouri's prescribing requirements described above, which delay access to LARCs for both postpartum and postabortion care.

But providers are still concerned about using devices that are purchased at reduced rates through the 340B program. While the procedure for LARC placement can be billed as a separate visit from the abortion procedure, providers worry that they may face scrutiny in how they use federal funds. So while there are often opportunities for women who want a LARC method after an abortion to receive one—including women covered by Medicaid—there may be financial and political fears that keep providers from administering comprehensive care.

New York

New York, a state with relatively few abortion restrictions,[81] has made efforts to increase the availability of all contraceptive methods postabortion. However, there are still knowledge gaps among providers and patients that hurt access. For both Medicaid and private insurance, LARC insertion can be billed the same day as an abortion as separate procedures on the same claim. The device itself is purchased

by the provider and then billed to the insurer. But while billing LARC methods in New York immediately after an abortion is relatively straightforward, a lack of knowledge among providers and patients is still a barrier. For providers, there can be misunderstandings about who is eligible for LARCs and, as with postpartum care, how to bill insertion on the same day.

Furthermore, many clinics still do not use LARC devices purchased through the 340B program or with Title X funds, as this practice may appear to violate the strict separation of federal funds and abortion services. So while Medicaid and most private insurers allow for same-day insertion, the provider often purchases the devices at full price.[82] Some clinics may have the experience and infrastructure to work with the different plans and have a stock of full-price devices, but many women are still without all contraceptive options after an abortion.

Education and training for providers

Underpinning provider confusion on both postpartum and postabortion LARC insertion is a lack of training programs. Despite federal support of increased access to LARCs generally, as of this writing, there are no known federal initiatives to increase provider understanding of LARCs postpartum and postabortion—a deficiency that must be addressed.

Focusing only on postpartum care, however, one recent innovative state model out of Delaware demonstrates an approach more states could take to improve providers' general understanding of LARCs. Recognizing "misunderstandings about medical eligibility that deprives women of same-day access to the full range of options," Delaware recently announced a first of-its-kind public-private partnership with Upstream USA to increase provider awareness of LARCs.[83] The program will provide training and advice to health centers across the state. The initiative has raised millions of dollars from philanthropic sources, while the state has reallocated about $1.75 million from the Delaware Division of Public Health budget for the project. The state estimates that by the end of 2017, more than 200,000 women will have access to the full range of contraceptive methods because of the program.[84]

Policy recommendations

While both federal and state improvements have increased access to postpartum LARC services, these efforts can be strengthened and expanded. In order to ensure that women can access postabortion LARC insertion, however, more significant changes must occur. In addition, both the federal government and states can improve provider understanding of LARCs.

Postpartum recommendations

Improvements in postpartum care could largely be accomplished through regulation and would not necessitate legislation.

Federal

Improve federal guidance on immediate postpartum placement

CMS should strengthen and issue guidance that ensures providers are able to easily bill for immediate LARC services postpartum. Ideally, CMS should issue guidance directing states to bundle LARC costs into delivery and labor services, as is currently being done in many states. Regardless of the approach, this guidance should represent best practices for billing for LARCs on the same day as delivery. By doing so, a national standard could be established to help increase provider knowledge and continuity of care.

A first step toward issuing such guidance could begin with a review of state initiatives—last completed in April 2016[85]—to identify the most effective programs. In order to ensure that women are able to access LARCs on the same day as a birth or an abortion, the guidance should not be limited to how to handle simultaneous billing: States must prohibit practices that cause delays in receiving LARCs, such as prior authorization for LARCs or being required to order a LARC in advance of a birth or an abortion in order to access it on the same day.

State

Build on other states' examples in expanding postpartum LARC access

Regardless of any improved guidance or requirements from the federal government, states can continue to expand their own efforts, as many states and the District of Columbia have already begun to do. As on the federal level, states should ensure that the cost of LARCs is bundled into labor and delivery services, though there are other strategies currently being undertaken that states could incorporate into their guidance as well.

Postabortion recommendations

While the changes needed to ensure postabortion LARC access are more sweeping than the changes needed for postpartum care, some smaller changes to policy could help improve access as well.

Federal

End the Hyde Amendment

Congress should eliminate federal funding restrictions on abortion care. Doing so would do a great deal to ease provider confusion over the role of federal programs and LARC insertion.

Issue clarifying guidance on federal funding for LARC access postabortion

Even if funding restrictions stay in place, CMS should issue guidance supporting LARC access immediately postabortion, while also explaining how billing can be done without violating the Hyde Amendment. This guidance, in order to ease provider confusion, should also make clear that LARC devices purchased through the 340B program or with Title X funds do not trigger federal prohibitions on using public funding for abortion care.

State

End state funding restrictions for abortion

Even if the Hyde Amendment were eliminated, state restrictions—such as those in more than half of U.S. states—would continue to complicate care. States should eliminate these prohibitions.

Issue clarifying guidance on state funding for LARC access postabortion

State health departments should issue guidance clarifying that billing for LARC insertion postabortion does not violate the state restrictions on Medicaid, along with guidance explaining how best to do so without violating these funding prohibitions. As with federal guidelines on the Hyde Amendment and LARC placement, this clarification would do much to improve provider understanding of patient eligibility.

Education and training recommendations

In addition to the above, federal and state governments should increase provider awareness and knowledge of LARCs and their use in postpartum and postabortion settings. Doing so would help ensure that LARCs are discussed more frequently, earlier, and with appropriate sensitivity.

Establish a federal pilot program for education and training on LARCs

The secretary of health and human services should establish a federal pilot program using funds from the Center for Medicare and Medicaid Innovation—which can authorize models to address "deficits in care leading to poor clinical outcomes"[86]—to test the effectiveness of different types of training programs on LARCs and the benefits of immediate postpartum and/or postabortion placement. The results of this program could then inform other federal and state training initiatives.

Establish state programs for education and training on LARCs

No matter whether the federal government acts to improve provider training programs, states should do their part by providing funds for state-run training programs through appropriate legislation or regulation. Delaware's public-private partnership could serve as a helpful model for states concerned with costs.

Conclusion

LARCs have proven to be highly effective, reliable, and cost-efficient methods of contraception, yet many women do not have immediate access to them postpartum and postabortion. While LARCs may not be the choice of every woman—and no one should ever be coerced into using a contraceptive they do not want—increasing their availability will help ensure that all women are able to exercise their reproductive rights.

Given the high percentage of unplanned births in the United States and the nation's high rates of maternal and infant mortality—as well as the fact that the best pregnancy and birth outcomes result from well-planned pregnancies—it is critical that all women have timely access to the contraceptive method of their choice. With proper counseling, choosing immediate LARC placement after a birth or an abortion can be an effective, convenient way to help patients prevent unintended pregnancies.

While more sweeping legislation that eliminates restrictions on public funds for abortion would be desirable, many obstacles to LARC access can be overcome through relatively simple policy changes at the federal and state levels.

Beyond the benefits of reducing rates of repeat unintended pregnancy, women want comprehensive contraceptive care after pregnancy and abortion. Policymakers and providers must ensure that all women have access to every option.

About the authors

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Endnotes

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