

Insurance Reimbursement for Post-Pregnancy Long-Acting Reversible Contraception (LARC)

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Background

In 2013, Hawaii had an unintended pregnancy rate of 52% (1). Unintended pregnancy carries significant health and economic consequences. LARC devices such as intrauterine devices (IUDs) and implants have been shown to decrease unintended pregnancy, adolescent pregnancy, and abortions in a highly cost effective manner. *The American Congress of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) endorse LARC as first-line contraception because of their high efficacy, ease of use, and minimal side effects.* LARC devices are important in post-pregnancy contraception (following delivery, miscarriage, abortion, ectopic, and molar pregnancies), and have been shown to decrease rates of unplanned, rapid repeat pregnancy. Currently, insurance coverage for post-pregnancy LARC is difficult to obtain due to bundled reimbursements, which limits the ability to provide effective contraception at a critical time when women are highly motivated to prevent a repeat pregnancy and already accessing healthcare.

Benefits of LARC

LARC methods are highly effective, with failure rates of 0.2-0.8% (2) and have very few side effects. They are easy to use, and require little to no effort following placement. There are very few contraindications to LARC and most women are good candidates for placement (3,4).

- Rapid repeat pregnancy: Pregnancy spacing is recognized as one of the “Healthy People 2020” goals. A pregnancy within 12 to 18 months after delivery occurs at a rate of 29% in Hawaii (5). Short inter-pregnancy intervals are associated with increased rates of preterm birth, low birth weight, and small for gestational age infants (6).
- Adolescent pregnancy: Hawaii has the 12th highest rate of adolescent pregnancy in the United States. A Colorado study on immediate postpartum insertion of the etonogestrel implant in adolescents demonstrated a significant difference in rapid repeat pregnancy at 12 months, with a rate of 18.6% in adolescents who did not undergo immediate placement compared to 2.6% in adolescents who did (7).
- Repeat abortion rate: Placement of LARC devices immediately after an induced abortion significantly decreases the number of repeat pregnancies (27.3% versus 15.3%), abortions (17.2% versus 9.9%), and births (7.9% versus 3.7%) within 12 months (8,9).
- High rates of continuation: The CHOICE Project, a study that offered same-day initiation of no-cost contraception to 9,000 women in the St. Louis area, demonstrated that when the barriers

of cost and access were removed 75% of women chose LARC and 77% were still using this method 24 months later (10).

Cost-Effectiveness of LARC

Reducing unintended pregnancies by improving immediate access to LARC methods can significantly decrease healthcare costs from unintended pregnancies, births, and abortions.

- Medicaid currently funds one-third of all births that occur in hospitals, approximately 6,000 births per year in Hawaii (11). Every dollar that is spent on contraception results in a savings of \$5.68 in Medicaid expenses (12).
- Despite concerns about increased IUD expulsion rates when placed immediately postpartum (12.3% at 12 month follow up compared to 3.3-9.2% when placed 6-8 weeks postpartum), immediate placement still results in an overall savings relative to planned placement at follow-up, due to the reduction in unintended pregnancies, births, and abortions (13).
- A study of repeat abortion rates in Canada demonstrated the lowest rates of repeat abortion in women who underwent immediate IUD placement compared to those who initiated oral contraceptive pills (OCPs) or medroxyprogesterone acetate (DMPA) injections (9). The 5-year overall cost was \$142.63 for women who had IUDs placed compared to \$385.61 for women who initiated OCPs (9).
- A cost analysis comparing immediate postabortal IUD placement to planned IUD placement at abortion follow-up noted savings in the immediate placement group of \$810 per woman over 5 years in direct medical costs, and \$4296 per woman over 5 years when social program costs were also considered (14).

Challenges

Currently, the major barriers to providing post-pregnancy LARC in Hawaii are related to billing and reimbursement. Most state Medicaid programs reimburse for all pregnancy, labor and delivery services using a single Diagnosis Related Group (DRG) code that does not incorporate reimbursement of individual procedures or devices provided immediately post-partum. LARC devices carry a high up-front cost and providers and hospitals are unable to provide LARC at the time of delivery without separate reimbursement for these methods.

At Kapiolani Medical Center for Women and Children a recent change in policy has allowed for LARC devices ordered from private medical offices for privately insured patients to be used in the hospital. This process requires multiple visits, pre-delivery planning, and ordering of the device prior to the patient's labor and delivery hospitalization. While this is a small improvement, it does not affect a large number of women, many of whom are at greatest risk for rapid repeat pregnancy. Additionally, providers are not reimbursed for the insertion of the LARC device.

Abortion services in Hawaii are covered by Medicaid fee-for-service, which provides reimbursement based on each service or procedure. Placement of a post-abortion LARC device may be done immediately following the abortion with certain Medicaid coverage plans, although reimbursement is often reduced based on the provision of two procedures in the same day (15). In states where Medicaid

does not provide coverage for abortion, federal Medicaid law reimburses services performed on the day of an abortion.

Studies have demonstrated that interval placement of LARC devices (placement in the outpatient setting), decreases the number of patients who receive the device, relative to immediate post-pregnancy placement. Six-month continuation rates are also higher for women who undergo immediate IUD or implant placement compared with women who await interval placement (18-20).

Opportunities

ACOG and Health Management Associates have released recommendations on the implementation of postpartum LARC programs (21) along with examples of states that have successfully implemented postpartum LARC programs. As of July 2015, thirteen states (California, Colorado, Georgia, Illinois, Indiana, Iowa, Louisiana, Maryland, Montana, New Mexico, New York, Oklahoma, South Carolina) have adjusted their Medicaid practices to reimburse for the insertion of postpartum LARC devices separate from global pregnancy-related fees. In most of these states the provider bills for the device and the insertion using a modifier code that indicates that the place of insertion is an inpatient hospital. To date, such state policies specify post-delivery, inpatient placement and do not account for all post-pregnancy insertions. While postpartum LARC is certainly an important service, these policies do not address the many women who desire a LARC device following an abortion, miscarriage, ectopic, or molar pregnancy and are unable to receive one due to persistent insurance barriers.

Hawaii has notably been a state with a history of progressive approaches to insurance coverage, such as the Hawaii Prepaid Health Care Act. An expansion in current policies to include all forms of post-pregnancy insertion, whether in an outpatient office or an inpatient hospital setting, would optimize prevention of undesired repeat pregnancy and maximize savings in statewide healthcare costs surrounding pregnancy management and care.

Recommendations

The following changes to the current policy in Hawaii would greatly improve access to LARC and thereby lower the rates of rapid unintended pregnancy and optimize use of healthcare resources.

- Implement changes to include coverage of postpartum implant/IUD device and insertion of the device as a procedure separate from the global delivery fee
- Implement changes to include coverage for all post-pregnancy LARC placement (post-abortion, post-miscarriage, post-ectopic, post-molar pregnancy), including the cost of the device and the insertion

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