Fact Sheet

Long-Acting Reversible Contraception (LARC)

One-half of pregnancies in the United States are unintended. Unintended pregnancy is associated with an increased risk of poor birth outcomes.[1] Long-acting reversible contraception (LARC) is safe and highly effective in preventing unintended pregnancies. Unlike other forms of birth control (such as barrier methods, birth control pills, and sterilization), LARC requires no user intervention, work over long periods of time, and can be reversed. LARC includes intrauterine devices (IUDs) and contraceptive implants that prevent ovulation. Despite recent advances in safety and effectiveness, these devices are not widely used in the United States. There are several barriers to the use of LARC, with out-of-pocket cost and insurance reimbursement being the most significant. This fact sheet provides an overview of LARC, the barriers that women and physicians face when choosing LARC, and public health solutions to reduce these barriers.

Why is LARC important?

The unintended pregnancy rate is a key public health indicator. Mistimed, unplanned, or unwanted pregnancies are associated with an increased risk of poor health outcomes for mothers and babies, including delayed access to prenatal care, preterm birth, and negative physical and mental health effects.[2,3,4] According to the National Survey of Family Growth, 51 percent of pregnancies in the United States are unintended, and the unintended pregnancy rate is 54 per 1,000 women ages 15-44.[5]

There are many contraceptive methods available for preventing pregnancy, including abstinence. More than 99 percent of women ages 15-44 who have ever had sexual intercourse have used at least one contraceptive method.[6] No method is 100 percent effective, except abstinence, and the success or failure of any method depends on a number of factors. Contraceptive implants and IUDs are highly effective and reversible contraceptive methods, with failure rates of less than one percent.[7] These methods are effective because they do not require user intervention, as opposed to methods such as birth control pills or condoms. LARC may also be ideal for many women who plan to have future pregnancies because they are reversible, unlike sterilization methods which are permanent. It is important to remember that LARC methods do not prevent sexually transmitted infection (STIs). Barrier methods, such as the male or female condom, should be used to help prevent the transmission of STIs. Women should consult their healthcare provider if they have any concerns about STIs.

LARC available to U.S. women have been approved by the Food and Drug Administration. In general there are very few contraindications, such as age or previous pregnancies, for their use.[8] They can be inserted at any time during a woman's menstrual cycle and they can be inserted immediately after miscarriage, abortion, or post-delivery.[9] Immediate insertion post-delivery has several benefits for a new mother, including fewer appointments and the convenience of not having to schedule and return for a follow-up procedure. This reduces the risk that women will not return for subsequent visits and procedures. Non-hormonal IUDs are especially beneficial for breastfeeding mothers.

Barriers to LARC

When intrauterine devices first came on the market in the 1970s they were relatively popular; however, when concerns of safety, infertility, and the fear (and misperception) that they caused STIs grew, women looked for other methods of birth control.[10] Providers and patients, and even mothers of patients, who remember the stigma of the early devices may be reluctant to choose LARC. Additionally,

2231 Crystal Drive, Ste 450, Arlington, VA
202-371-9090
www.astho.org

because of the decreasing popularity of IUDs, providers may not have had experience placing IUDs during their training. Despite recent advances in the safety and effectiveness of IUDs and contraceptive implants and their very low failure rates, U.S. women have not adopted LARC in large numbers. In 2009, among women using contraception, less than nine percent relied on LARC—representing only a modest increase from 2007 (5.5%) and 2002 (2.4%).[11] Patients and healthcare providers face many barriers related to awareness about the safety and effectiveness of LARC. In addition, a lack of insurance reimbursement procedures and inadequate supplies pose challenges for implementation of LARC insertion in cost-effective and time-efficient ways. Mitigating these barriers can broaden the contraception choices for women.

Patient Barriers

A general lack of awareness about the effectiveness and safety of LARC is documented as a barrier for women who access family planning and contraceptive services. Women describe the ideal contraceptive as reversible and requiring little intervention.[12] Studies have found that women are more likely to have a favorable attitude about IUDs after they received information about the devices.[13,14] Cost is also a significant barrier for many women. The up-front, out-of-pocket costs (between $500 and $1,000) of LARC methods can be cost prohibitive for women who are uninsured or underinsured.

Provider Barriers

Lack of provider knowledge is another barrier to LARC use. According to the American Congress of Obstetricians and Gynecologists (ACOG), although providers generally have positive attitudes about implants and IUDs, they may be overly restrictive in identifying candidates based on clinical indications and patient histories.[15] Providers may also feel less confident or experienced in placing devices and therefore reluctant to recommend them to their patients.[16] Providers and patients may also be burdened and discouraged by misperceptions and misinformation that multiple visits and certain tests are required for placement. ACOG supports efforts to increase education and offers hands-on training opportunities for clinicians in implant and device insertion.[17]

Systemic Barriers

Up-front costs of implants and IUDs are high and often not fully covered by insurance. Even though the Affordable Care Act mandates that approved prescription contraceptive methods, including IUDs and implants, be covered 100 percent by the insurance plan, some insurers are not adequately complying.[18] The medical exam, the implant or IUD itself, insertion of the device, and follow-up visits can range from $500-$1,000.[19] Providers and healthcare facilities are reluctant to stock LARC in their office and provide them in single office visits or immediately post-delivery because of inadequate insurance reimbursement procedures. The lack of insurance coding for reimbursement that separates this procedure from delivery makes LARC insertion cost prohibitive for physicians and hospitals, and the likelihood that new mothers will return for LARC insertion falls dramatically because of these delays.[20]

State Initiatives

Medicaid Reimbursement for Post-Delivery Insertion

Due to the fact that the up-front costs of LARC are cost prohibitive for many women, and because of a number of visits may be required for the exam, insertion, and follow-up, some women and doctors may be discouraged from choosing LARC methods. Negotiating public insurance reimbursement for immediate post-delivery women is a strategy that is being considered across the country. States that have already introduced reimbursement procedures include South Carolina, New Mexico, Iowa and

Alabama. Coverage for LARC is considered an add-on benefit to the Diagnostic Related Group and hospitals are required to use the Healthcare Common Procedure Coding System Code that represents the device, along with the ICD-9 Surgical Codes and the ICD-9 Diagnosis Codes that best describe the services delivered.

Public-Private Partnerships

Public-private partnerships provide low-cost family planning and preventive health services to patients, create marketing strategies aimed at both providers and the public, and demonstrate the potential of fully-funded Title X clinics. The Colorado Initiative to Reduce Unintended Pregnancies and the Iowa Initiative to Reduce Unintended Pregnancies are coalitions of community organizations, family planning providers, and advocacy organizations and coalitions. Their goals are to increase access to family planning, improve the political climate around family planning, and ultimately reduce unintended pregnancies in their states. The partnerships have allowed clinics to train staff on the benefits of LARC and how to use them, hire additional staff and expand clinic hours, purchase LARC at low cost or no cost to their patients, and produce social marketing campaigns aimed primarily at teens and college students. The websites beforeplay.org (Colorado) and avoidthestork.com (Iowa) were developed as part of the partnerships and provide information on STI and pregnancy prevention for sexually active youth. Colorado saw significant progress in the reduction of repeat pregnancies among teens. More than 50 percent of Colorado postpartum teens reported using LARC (compared to the national average of 22 percent) and the number of adolescent repeat births fell 45 percent from 2008-2012.[21] In Iowa, private funding increased the capacity of Title X clinics to provide services, and the number of men and women receiving family planning services at Title X agencies increased 11 percent from 2007 to 2010. In the same time frame, the number of Iowa women using an IUD or implant as their primary birth control method increased 218 percent and 829 percent respectively.[22] The percent of unintended pregnancies in Iowa decreased five percent and the number of abortions decreased 19 percent from 2007-2010.[23]

Suggested State Actions

- Advocate for coverage and reimbursement of all contraceptive methods, including LARC, by all insurance plans, public and private.
- Work with state Medicaid program to offer immediate post-delivery contraception, including implants and IUDs. Assure reimbursement for the cost of devices.
- Develop or strengthen partnerships between local and state health departments and ACOG to promote the availability of public and private programs that provide affordable LARC options.
- Utilize Title X and other federal funding to support the provision of LARC in family planning clinics.
- Encourage other federally supported clinical sites, such as federally qualified health centers (FQHCs) to provide LARC.
- Support and advocate for professional development opportunities about LARC for clinicians who provide family planning services.
- Incorporate the promotion of LARC into current efforts to reduce unintended pregnancy and improve birth outcomes.

[1] Barber JS, Axinn WG, Thornton A. "Unwanted childbearing, health, and mother-child relationships." *Journal of Health and Social Behavior*. 1999. 40(3):231-257.

[2] Mayer JP. "Unintended childbearing, maternal beliefs, and delay of prenatal care." *Birth*. 1997. 24(4):247-252.

[3] Orr ST, et al. Unintended pregnancy and preterm birth. *Paediatric Perinatal Epidemiology*. 2000. 14:309-313.
[4] Barber JS, Axinn WG, Thornton A. "Unwanted childbearing, health, and mother-child relationships." *Journal of Health and Social Behavior*. 1999. 40(3):231-257.
[5] Finer L, Zolna M. "Shifts in intended and unintended pregnancies in the United States, 2001-2008." *American Journal of Public Health*. 2014. 104:S43-S48. Available at http://www.guttmacher.org/pubs/journals/ajph.2013.301416.pdf. Accessed 2-24-2014.
[6] Daniels K, Mosher W, Jones J. "Contraceptive methods women have ever used: United States, 1982-2010." *National Health Statistics Reports*. 2013. Issue 62. Available at http://www.cdc.gov/nchs/data/nhsr/nhsr062.pdf. Accessed 2-24-2014.
[7] *Ibid*.
[8] ACOG. "Increasing use of contraceptive implants and intrauterine devices to reduce unintended pregnancy." *ACOG Committee Opinion.* 2011. Available at http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Gynecologic%20Practice/co450.pdf?dmc=1&ts=20130529T0357139633. Accessed 2-24-2014.
[9] CDC. "Classifications for intrauterine devices: Appendix E." *MMWR.* 2010. 59(RR04):52-63. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5904a6.htm. Accessed 3-13-2014.
[10] Hubacker D. "The checkered history and bright future of intrauterine contraception in the United States." *Perspectives on Sexual and Reproductive Health."* 2002. 34:2. Available at http://www.guttmacher.org/pubs/journals/3409802.html. Accessed 3-13-2014.
[11] Finer LB, Jerman J, Kavanaugh ML. "Changes in use of long-acting contraceptive methods in the United States, 2007-2009." *Fertility and Sterility*. 2012. 98:893-897. Available at http://www.guttmacher.org/pubs/journals/j.fertnstert.2012.06.027.pdf. Accessed 2-24-2014.
[12] Cwiak C, Gellasch T, Zieman M. "Peripartum contraceptive attitudes and practices." *Contraception*. 2004. 70:383-6.
[13] Whitaker AK, Johnson LM, Harwood B, *et al. "*Adolescent and young adult women's knowledge of and attitudes toward the intrauterine device." *Contraception*. 2008. 78:211-7.
[14] Dempsey A, Savage A, Billingsley C, Korte J. "Predictors of long-acting reversible contraception use among unmarried young adults." *Contraception*. 2011. 84:317.
[15] ACOG. "Increasing use of contraceptive implants and intrauterine devices to reduce unintended pregnancy." *ACOG Committee Opinion.* 2011. Available at http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Gynecologic%20Practice/co450.pdf?dmc=1&ts=20130529T0357139633. Accessed 2-24-2014.
[16] *Ibid.*
[17] *Ibid.*
[18] Sonfield A. "Implementing the federal contraceptive coverage guarantee: progress and prospects." *Guttmacher Policy Review.* 2013. 16:4. Available at http://www.guttmacher.org/pubs/gpr/16/4/gpr160408.html. Accessed 3-13-2014.
[19] Planned Parenthood. "Birth control methods–birth control options." Available at http://www.plannedparenthood.org/health-info/birth-control/iud. Accessed 2-24-2014.
[20] AGOC. "Medicaid reimbursement for immediate post-partum LARC." *Health Management Associates*. May 2013. Available at http://www.acog.org/About_ACOG/ACOG_Departments/Long_Acting_Reversible_Contraception/Coding_and_Reimbursement_for_LARC/~/media/Departments/LARC/HMAPostpartumReimbursmentResource.pdf. Accessed 2-24-2014.
[21] Booth M. "Colorado teen birth rate plunges, far fewer second children." *The Denver Post.* April 2013. Available at www.denverpost.com/ci_22930430/colorado-teen-birth-rate-plunges-far-fewer-second. Accessed 2-27-2014.
[22] Phillliber Research Associates. "Reducing unintended pregnancies in Iowa by investing in title X clinics." Available at http://www.phillliberresearch.com/files/Reducing-Unintended-Pregnancies-in-Iowa-by-Investing-in-Title-X-Clinics.pdf. Accessed 2-27-2014.
[23] *Ibid.*