

# HEALTH POLICY AND ACCESS TO LONG-ACTING REVERSIBLE CONTRACEPTIVES:

## A DESCRIPTION OF RECENT POLICY EFFORTS TO INCREASE ACCESS TO LONG-ACTING REVERSIBLE CONTRACEPTIVES.

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Long-acting reversible contraceptives (LARCs), including intrauterine devices (IUDs) and contraceptive implants, are safe and effective methods for preventing unintended pregnancy.<sup>1</sup> LARCs are 99% effective, they require little ongoing effort by patients, and they can be removed when a patient wishes.<sup>1</sup> Both the American Academy of Pediatrics and the American College Obstetrics and Gynecology recommend that LARCs be offered on a routine basis, to patients of reproductive age.<sup>2</sup>

Despite the advantages that LARCs offer to patients that desire them, they are also uniquely difficult to deliver in the U.S. health care system. The acquisition cost per unit for LARC devices is high relative to other methods and clinics may have difficulty keeping adequate stock on hand.<sup>3</sup> Without payment mechanisms in place to adequately reimburse providers they may be prohibitively expensive to offer. LARC devices also require additional clinical training on appropriate counseling, placement, and removal. These factors, in addition to patient awareness, may create systemic barriers to offering LARC services at the clinic-level.

To overcome these challenges, there has been efforts to adopt policies that will increase access to long-acting reversible contraceptives. This brief describes on-going state and federal efforts to increase LARC access, the background motivating this policy push, and potential unintended consequences to reproductive justice.

## BACKGROUND

In 2011, 45% of pregnancies were unintended in the United States.<sup>4</sup> A pregnancy is considered unintended if a woman indicates that the pregnancy was unwanted or occurred sooner than desired. Unintended pregnancy, as a measure of reproductive autonomy, has been widely used by researchers and policymakers for planning and evaluation of public health interventions. Despite the widespread adoption of pregnancy intention as an indicator of reproductive autonomy, its measurement is complex and accurate interpretation (like other population-level indicators) relies on an understanding of the measure's flaws.

Recent challenges to its use as a sole measure of reproductive autonomy cite a growing understanding that pregnancy desires can change over time,<sup>5</sup> it is difficult to accurately capture (requiring data from multiple sources), and other measures (that are perhaps less conceptually and methodologically challenging to track) exist.<sup>6,7</sup> While some would like to see data collection on pregnancy intention discontinued in favor of alternative access measures, such as access to contraception and abortion services, this may limit the ability of policymakers to address reproductive autonomy in a way that fully captures pregnancy desires.<sup>7</sup>

U.S. policy makers have been interested in reducing unintended pregnancy since at least the introduction of the Title X family planning program in the 1960's. In 2010, the contraceptive care mandate, which barred cost-sharing for contraceptives in the private market, was a major cornerstone and flashpoint of the Affordable Care Act. While basic questions of access to the full gamut of family planning services remains a focus of policy debate, access to LARCs specifically has garnered considerable recent attention.

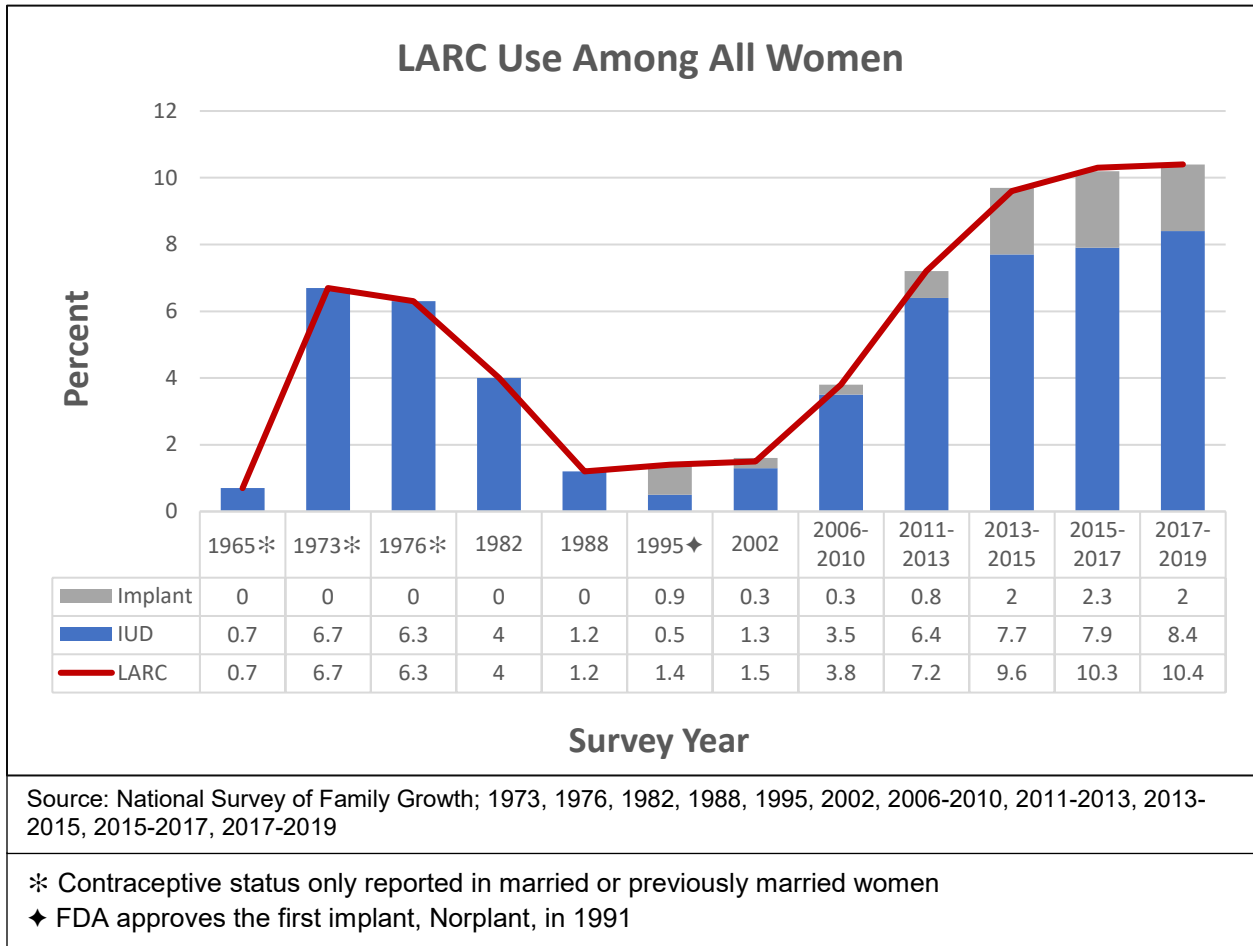
## HISTORY OF LARC & CURRENT USE

Rates of LARC usage tend to be higher worldwide than in the US. In 2019, estimated worldwide usage of LARC methods among all women (15-49 years of age) was 19%.<sup>8</sup> In contrast, LARC usage among all women in the United States (15-49 years of age) in 2019 was 10.4%, making it the third most common method behind sterilization (18.1%) and contraceptive pills (14%).<sup>9</sup>

Figure 1 plots LARC usage rates from 1965 to 2019, estimated from the National Survey of Family Growth. The first generation of IUDs became available in 1968, and by 1973 approximately 10% of US women using any method of contraception were choosing IUDs.<sup>10</sup> IUD use among US women overall (15-44 years of age) hovered above 6% in these early years. However, use of the method declined rapidly as thousands of women experienced serious health issues associated with Dalkon Shield IUDs, and several manufacturers pulled their devices from the US market. This event likely explains the significant drop in LARC use from 1982 to 1988, as shown in Figure 1, where rates dropped to a low of less than 2% in 1988.

The Dalkon Shield IUD was significantly different in design and development than IUDs available today. The crab-shaped device was associated with over 200,000 claims of serious medical issues such as pelvic inflammatory disease, miscarriage, loss of fertility, and death.<sup>11</sup> Dalkon Shield's string was unsealed, resulting in fraying and disintegration, and was found to draw vaginal bacteria into the uterus. Additionally, at the time Dalkon Shield became available on the market, Food and Drug Administration (FDA) approval was not required as it was not considered a drug. Dalkon Shield was pulled from the market in 1974, and in 1976 congress passed federal legislation requiring the FDA conduct safety and efficacy testing of IUDs before they can be marketed and approved.<sup>11</sup>

**Figure 1: Trends in Long-Acting Reversible Contraceptive use, by device**



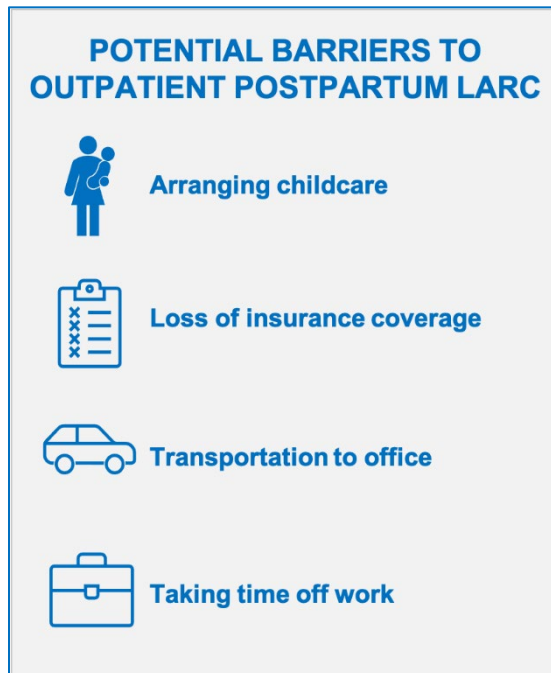
Paragard -- a new copper IUD -- was introduced in 1988, and Mirena - a new hormone-releasing IUD - was introduced in 2001, although uptake for both was negligible in early years.<sup>12</sup> As depicted in Figure 1, there is substantial growth in the use of LARCs from 2011 forward. This coincides with several provisions of the Affordable Care Act to improve coverage, remove cost barriers, and increase access to health insurance. The use of LARCs more than tripled from 1.5% in 2002 to 7.2% in 2011-2013, following the implementation of the Affordable Care Act's new contraceptive coverage requirement and cost-sharing prohibitions.<sup>13</sup> By 2017-2019, 10.4% of US women were using a LARC method (Figure 1).

## **BARRIERS AND CHALLENGES ASSOCIATED WITH LARC UPTAKE**

Many barriers exist that make LARC uptake more difficult or in some cases impossible. These barriers arise at the patient-level, provider and clinic-level, and system-level.

## Patient-level

A primary barrier for women in obtaining LARC is high upfront costs. For women who are uninsured or underinsured, estimated total cost of initiating LARC can be upwards of \$500-\$1000 for insertion, cost of device, and follow-up visit.<sup>14</sup> LARCs typically require more than one office visit before initiation, as high device acquisition costs make it difficult for hospitals and clinics to stock LARC devices and provide same-day insertion. The additional time and cost of a second office visit is a deterrent for many women who initially choose a LARC method; nearly half of all women who order LARC do not return for insertion when the two-visit protocol is used.<sup>15</sup> Double billing practices for IUDs and implants, once for insertion and once for removal, present financial barriers for women who may lack insurance or have inconsistent coverage. This practice can also increase patient-associated costs in terms of lost days at work, transportation, and childcare. Such burdens for LARC acquisition disproportionately impact low-income women who choose long-acting reversible contraceptives.<sup>14</sup>



Source: University of Delaware, Center for Community Research & Service, 2021

These barriers can be especially problematic for adolescents who lack the independence necessary to obtain LARC, and who may not want their parents aware of their contraceptive choices. Federal regulations state that minors can seek contraceptive care from federal sources without parental consent, however, state laws governing consent for privately insured minors vary. As of December 2020, 27 states and the District of Columbia allowed all individuals to consent to contraceptive services or those at a specified age to consent to care.<sup>16</sup> However, even if adolescents are able to independently obtain contraceptives, this does not necessarily guarantee confidentiality. Some billing practices can compromise confidentiality, especially if minors are insured through their parent's benefits.<sup>16</sup>

Additional challenges associated with initiation include patient knowledge, attitudes, and beliefs regarding long-acting reversible contraceptives. Surveys and interviews with women often find a lack of knowledge about LARC methods as well as concerns about side effects. Some women are not familiar with LARC methods and may not be aware of their overall safety and efficacy.<sup>17</sup> Uneasiness about LARC may also be a result of differences in knowledge about birth control and reproductive health among poor and minority communities and may be related to broad societal factors such as lower levels of education,<sup>18</sup> culturally or religiously based beliefs and differences in familial communication about reproductive health.<sup>19</sup>

### *Provider and Clinic-level*

Lack of provider knowledge about the safety and effectiveness of LARCs, combined with insufficient training in insertion and removal of LARC devices, are often-cited barriers to LARC usage.<sup>20</sup> Some providers also believe that LARCs should not be used by women who have never given birth or by women immediately after birth or after an abortion, which research states is inaccurate.<sup>21</sup> A lack of LARC education among providers has been observed as particularly present in federally qualified health centers that primarily serve women of low socio-economic status.<sup>22</sup> Providers may be less inclined to initiate conversations with patients about LARC methods due to these misconceptions. Surveys of medical providers have demonstrated reservations in providing LARCs because of a risk of infection and liability.<sup>23</sup>

Other commonly cited barriers to providing LARC at the provider and clinic-level are challenges with reimbursement, lack of familiarity with insurance policies, and high wholesale acquisition costs of stocking LARC devices and therefore not having devices available onsite to provide same day insertion.<sup>24</sup>

### *System-level*

Perhaps the most obstructive barriers to LARC uptake exist at the health system level. While reimbursement for LARC methods exists under both public and private coverage models, uniformity of coverage is lacking. The Affordable Care Act contraceptive mandate stipulates LARC (and other FDA-approved methods) must be covered without cost-sharing in all health insurance plans from August 2012 forward.<sup>13,25</sup> However, women in non-expansion states or on grandfathered plans prior to 2012 may not receive the same coverage, depending on the policies in their state. Additionally, despite coverage requirements and stipulations within the ACA, a 2015 study found that many private insurers were not complying with the coverage mandate by denying coverage, requiring cost-sharing, or otherwise restricting access.<sup>25</sup>

There are additional reimbursement challenges in the inpatient setting, specifically immediately after birth. Immediate postpartum (IPP) LARC refers to LARC initiation in the immediate postpartum period before hospital discharge. As discussed below, many states are leading efforts to promote IPP LARC and amend their Medicaid payment model for labor and delivery. Previously, Medicaid only made a single bundled payment for labor and delivery costs regardless of the services provided, and thus excluded the reimbursement of LARC. If state Medicaid agencies have not carved out LARC reimbursement from the bundled payment, referred to as the global maternity fee, providers and hospitals cannot be reimbursed for the full acquisition cost of the device, and therefore may not offer it to Medicaid enrollees. Studies demonstrate that extending Medicaid coverage of IPP LARCs resulted in women being 2.5 times as likely to choose a LARC as their postpartum contraceptive method,<sup>26</sup> and also improved birth intervals for at-risk populations.<sup>27</sup>

An additional system-level barrier at the provider-level is the inability to stock LARC devices for same-day insertion.<sup>14</sup> This impacts hospitals, individual providers, and clinics such as federally qualified health centers (FQHCs). FQHCs serve a predominantly lower-income population, Medicaid enrollees and

uninsured individuals, and therefore may be less able to bear the large upfront costs of supplying a stock of LARC.<sup>22</sup> This ultimately makes access difficult for low-income women who benefit from these clinics.

Lastly, a less common yet notable barrier impacting access to LARC at the system-level is the Ethical and Religious Directives for Catholic Healthcare Services (ERD). The ERD is a set of guidelines for healthcare delivery issued by the US Conference of Catholic Bishops, by which Catholic Hospitals must abide. These guidelines prohibit access to common reproductive services at such facilities, including LARC.<sup>28</sup> ERD guidelines can put providers employed within Catholic systems in a difficult position, especially if they do not share the same views as their employer and feel they have a duty to provide care.<sup>28</sup> The Affordable Care Act provided narrow exclusions to the contraceptive mandate which included certain eligible nonprofit and religious employers. In 2017, the Trump Administration issued regulations broadening the definition of a religious employer and expanding exemption eligibility, most of which were upheld by the Supreme Court.<sup>29</sup> However, fully-insured (not self-insured) employers must comply with both federal and state law.<sup>29</sup> As of July, 2021, of the 20 states with a refusal provision, 10 states meet or exceed the ACA refusal clause.<sup>30</sup>

## **POLICY RESPONSES**

### **THE AFFORDABLE CARE ACT**

The Affordable Care Act (ACA) altered the delivery of family planning services and expanded access to those services by making health insurance more available through public and private market reforms. One of the most notable ways the ACA influenced access to contraceptive services was by removing patient out-of-pocket expenses. Under the ACA all non-grandfathered plans across all markets are required to make the full range of FDA-approved contraceptive services and supplies, in addition to other preventive services, available without cost-sharing. This provision allows for the exemption of some religious employers, a topic which has been the focus of recent national debate.<sup>13</sup>

In addition to the preventive services mandate, the ACA also prohibited coverage decisions based on pre-existing conditions and implemented modified community rating in the individual and small group markets. Under this rating system premiums can only be adjusted based on the number of enrollees, geography, age, and tobacco use. This prohibited premium adjustment based on health status and gender (gender rating).<sup>31</sup>

Although these private market reforms did much to expand access to insurance coverage and services, most recent family planning-related policies have taken place in the Medicaid program, which serves the population who are least likely to use contraceptive methods.<sup>32</sup>

As a key provision of the ACA, states were given the option to expand Medicaid eligibility to childless adults with incomes below 138% of the Federal Poverty Level (FPL), effective January 1, 2014.<sup>33</sup> Nationally, enrollment in Medicaid and the Children's Health Insurance Program (CHIP) has increased by more than 18 million compared with 2013 levels (the year prior to federal implementation).<sup>34</sup> Currently

39 states have adopted the Medicaid expansion.<sup>41</sup> The Medicaid program's broad flexibility gives states the ability to implement substantial reforms associated with LARC access.

## LARC & MEDICAID

There are various pathways states can use to increase access to LARC and family planning services. Family planning services and supplies are "mandatory" benefits under Medicaid and must be provided to beneficiaries free of cost-sharing.<sup>35</sup> However, there is no formal definition of "family planning", so states have some discretion as to which services they include in this category.

In addition to the baseline coverage requirements mandated by Federal law, some states may choose to expand Medicaid coverage of family planning services through a Section 1115 demonstration waiver from the Centers for Medicare & Medicaid Services (CMS). These waivers extend Medicaid coverage for family planning services only to women and men who are not otherwise eligible for full-scope Medicaid.<sup>35</sup> These waivers are common in states that did not choose to expand Medicaid to childless adults. States can also establish limited scope family planning programs by adopting "state plan amendments" (SPAs) without requesting a federal waiver of Medicaid rules.<sup>35,36</sup>

### Summary of State-Level Strategies to Increase LARC Access:

- ⇒ De-bundling Immediate Postpartum LARC
- ⇒ Addressing Upfront Costs
- ⇒ Addressing Educational Barriers for Patients and Providers
- ⇒ Incentivizing LARC

### *Addressing Upfront Costs*

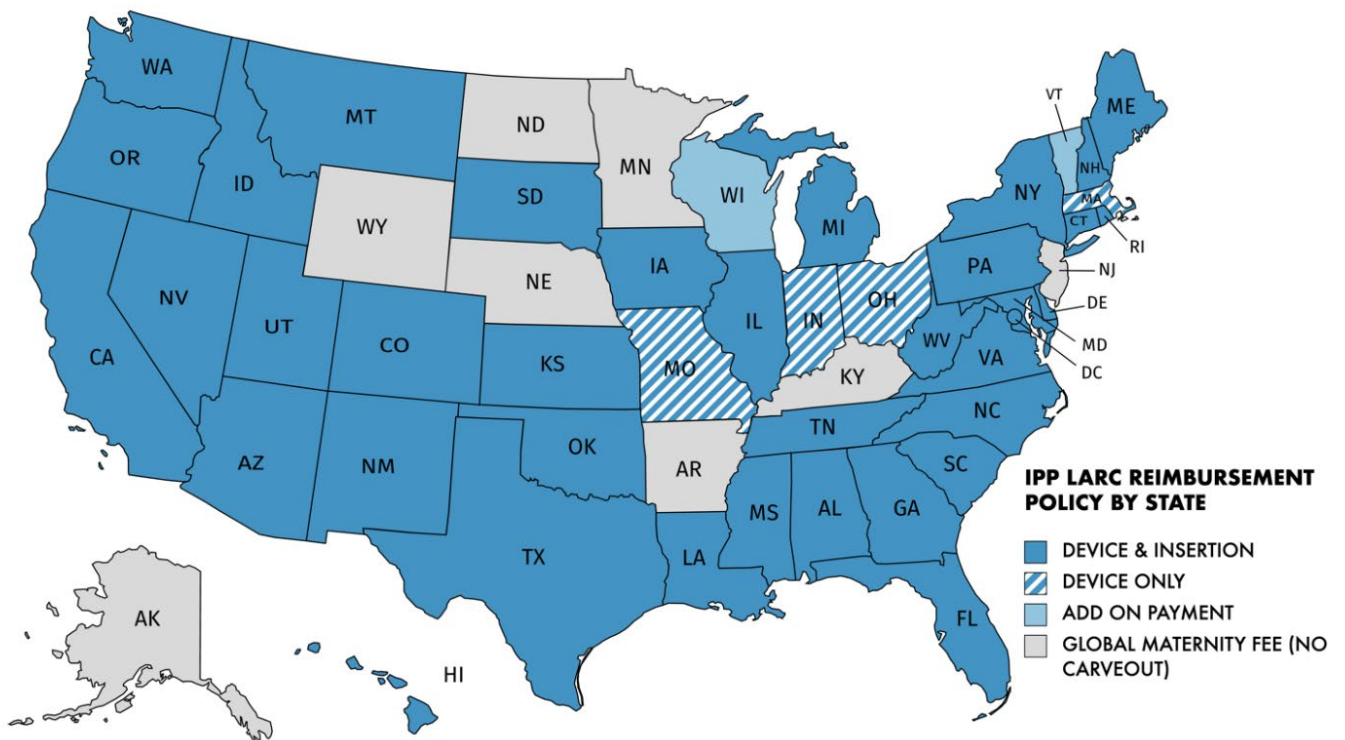
Costs of LARC initiation were addressed for patients with insurance coverage by the ACA but remained an obstacle for some Medicaid providers in both inpatient and outpatient settings. The ability to offer LARCs on the same date of service requires sufficient stock of devices as well as mechanisms to sufficiently pay providers.

In the inpatient setting the bundled payment most state programs use to pay providers for maternity care may not cover the acquisition cost of LARC devices. This puts providers in a position to either forego offering immediate postpartum LARC or lose money offering the service. Most states have approached this issue by de-bundling the cost of LARC devices, insertion, or both from the bundled maternity fee. Others have used add-on payments to cover the acquisition cost of the devices in the inpatient setting. These payment reforms have been implemented by states using 1115 waiver authority or state plan amendments.<sup>35</sup>

Although LARC can be placed at a postpartum follow up visit, up to 40% of women may not receive outpatient postpartum care, often due to transportation, childcare, and employment barriers.<sup>37</sup> Additionally, nearly half of all delivering women face a period of lack of insurance coverage in the 6 months after delivery, and therefore may no longer be able to afford LARC.<sup>38</sup> This makes the timing of postpartum LARC placement extremely important. Many federal and state health officials have publicly encouraged payers to revise their IPP LARC reimbursement models, and the Centers for Medicare and Medicaid Services encourages this practice.<sup>39</sup>

Figure 2 provides an overview of immediate postpartum LARC reimbursement policies by state. Currently, only five states still do not provide some type of reimbursement for immediate postpartum long-acting reversible contraceptives.

**Figure 2: Immediate Postpartum LARC Reimbursement Policies by State (As of 2020)**

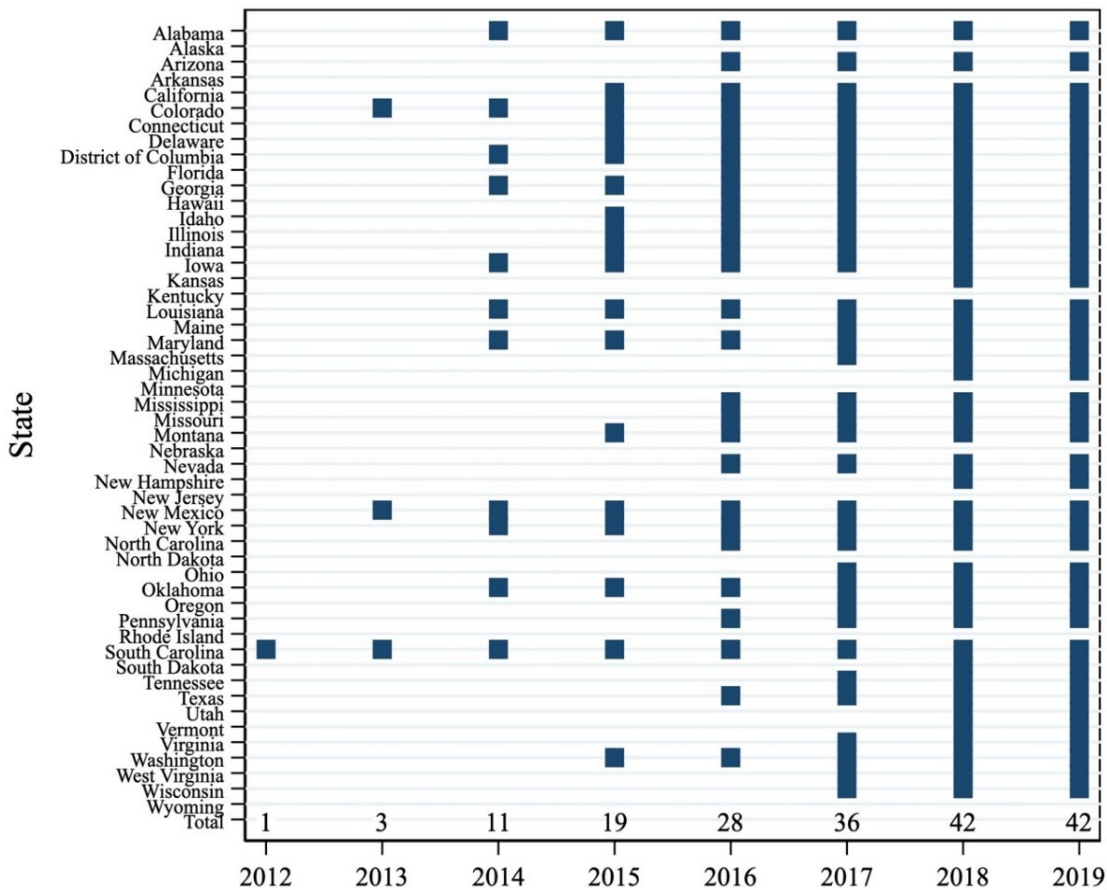


Source(s): State Plan Amendments (SPAs), State Medicaid Family Planning Provider and Billing Manuals, telephone interviews with State Medicaid Agencies, [American College of Obstetricians and Gynecologists. \(2020\). Medicaid Reimbursement for Postpartum LARC](#)



A timeline of state approaches to IPP LARC reimbursement reform is provided in Figure 3. Colorado (2013), New Mexico (2013), and South Carolina (2012) were early adopters of this approach to enhance LARC provision in the Medicaid program. There was widespread national adoption by 2019 with 42 states and the District of Columbia implementing similar reforms to reimburse separately for postpartum LARC. Despite widespread adoption, there is limited evidence on whether these reforms are effective at altering provider behavior and increasing patients' ability to choose the method that's most appropriate for them. An evaluation of South Carolina's policy suggests the carve-out was, indeed, associated with increased availability of immediate postpartum LARC.<sup>40</sup> Despite implementation at the state-level, broad facility-level adoption remained a challenge suggesting that beyond policymaking, enhancing provider awareness may support improved policy take-up and provision of immediate postpartum LARC among the Medicaid population.<sup>40</sup> However, given the variation in health system operations and variations in payment reform approaches from state to state, more research is needed to understand whether these policies meet their intended goals.

**Figure 3: IPP LARC Payment Reform Implementation by State and Year**



Source(s): State Plan Amendments (SPAs), State Medicaid Family Planning Provider and Billing Manuals, telephone interviews with State Medicaid Agencies, [American College of Obstetricians and Gynecologists. \(2020\). Medicaid Reimbursement for Postpartum LARC](#)

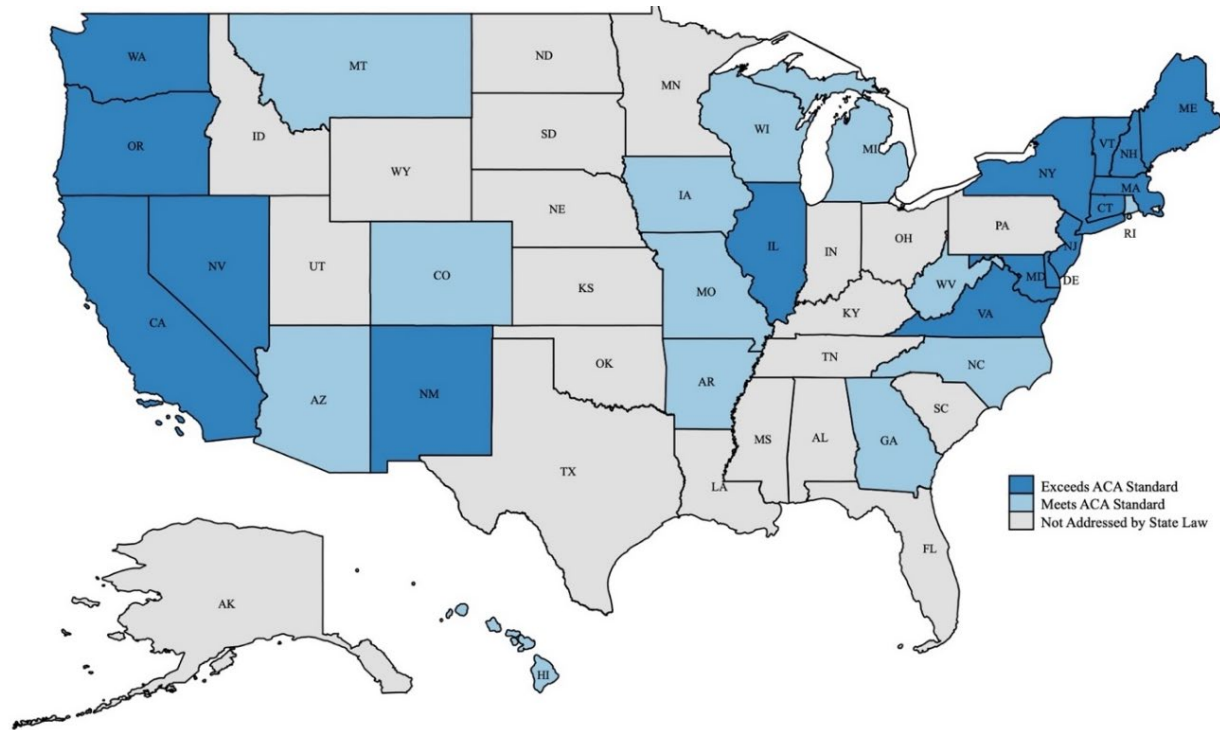
Ensuring adequate stock is another problem faced by providers and practices. Specialty pharmacy “white bagging” refers to a method of stocking LARC devices in an outpatient clinic where the ordering provider is not charged for the device at any point.<sup>39</sup> This method is designed to overcome the challenges providers face with stocking LARC devices. With this strategy, the provider can charge the device directly to a patient’s Medicaid plan and therefore does not have to absorb the upfront cost of the device. The device is typically shipped overnight to the office and is inserted within 30 days.<sup>39</sup>

In addition to the “white bagging” pharmacy benefit, states are finding additional ways to overcome LARCs high upfront costs. Several state Medicaid agencies are considering payment models designed to remove barriers resulting from current billing methods. In Texas for example, providers working with Medicaid or the Texas women’s health program are able to order LARC devices from select pharmacies at no upfront costs.<sup>39</sup>

## GENERAL CONTRACEPTIVE POLICIES

In recent response to Federal attempts to undermine the ACA contraceptive coverage mandate, and because gaps in contraceptive coverage remain, some states have taken steps to pass legislation to meet or exceed coverage requirements under the ACA. These efforts build on previously passed state Contraceptive Parity laws, which require contraceptives to be covered in the same manner as any other prescription drugs and medical services.<sup>41</sup> State “contraceptive equity” laws vary by state, but are designed to apply to state regulated private and public health insurance programs.<sup>29,41</sup> Common provisions include state requirements that plans cover the full range of contraceptive methods and services without cost-sharing (consistent with federal rules), limit medical management and utilization controls, and create gender equity in contraceptive coverage. Contraceptive equity laws may protect against future barriers to accessing LARC.<sup>41</sup> For example, contraceptive equity laws that strictly limit the ability of insurers to impose restrictions and delays, known as medical management, may improve LARC initiation and reduce administrative burden.

**Figure 4:** State-level coverage of prescription contraceptives (as of May 2021)



Source: Guttmacher Institute. (2021). *Insurance Coverage of Contraceptives*. <https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives>. Washington, D.C. (not displayed) exceeds ACA standard as of May 2021.

Currently, 30 states and the District of Columbia meet or exceed the federal standard set under the ACA provision (Figure 4). Under federal law, all new (non-grandfathered) private plans are required to cover the full range of contraceptive methods and services including counseling, initiation, and follow-up care without cost-sharing.<sup>13</sup> States exceeding federal rules may require coverage for an extended supply of contraceptives, require coverage for male sterilization, and prohibit health plan restrictions. A limited number of states have also expanded pharmacist scope of practice laws, allowing pharmacists to prescribe and dispense hormonal methods.<sup>42,43</sup>

## COMPREHENSIVE PROGRAMS

Additional efforts to expand provider knowledge and training are being implemented locally and at the state level. The Colorado Family Planning Initiative (CFPI) funded provider and staff training on counseling and insertion techniques, expansion of clinic hours, and technical assistance on coding, billing, and management starting in 2009.<sup>44</sup> This was a unique initiative that extended investment beyond the patient. As a result of the CFPI, 23% more women were able to be seen in Colorado clinics, and among the targeted group LARC use quadrupled in 3 years.<sup>44</sup> The CFPI also saved the state an estimated \$79 million in the first three years alone.<sup>44</sup>

The St. Louis Contraceptive CHOICE Project addressed educational barriers for patients. Launched in 2007, the CHOICE project was designed to study which contraceptives women choose when cost, education, and access barriers are reduced.<sup>45</sup> This project developed a comprehensive contraceptive counseling program that provided unbiased information on all contraceptive options to help participants determine the best method for them. Results from the project reported that 75% of participants chose a LARC method,<sup>45</sup> and the rate of teen pregnancy for women in the study was more than 4 times lower than the national rate.<sup>46</sup> The findings of the CHOICE project show that when women are equipped with unbiased, accurate information, as well as adequate access and financial means, they tend to choose the most effective forms of contraception and subsequently experience better health outcomes as a result. This project also demonstrates the significance of a patient-centered contraceptive counseling process.

### *Incentivizing LARC*

An additional approach to increasing LARC use that some states are testing is to incentivize the use of highly effective birth control methods. Illinois changed its payment model in 2014 to provide additional reimbursement for contraceptive methods that demonstrate high efficacy. The new policy required that Medicaid patients receive counseling and education on all birth control methods, with information about the most effective presented first.<sup>47</sup> This policy also doubled the provider reimbursement rate for IUD insertion and increased the medical provider's dispensing fee for LARC.<sup>47</sup> These changes were aimed at structuring incentives to encourage providers to learn more about LARC.

#### **DELAWARE CONTRACEPTIVE ACCESS NOW (DeICAN) INITIATIVE:**

DeICAN — a partnership between the State of Delaware and Upstream USA—provided evidence-based training for clinicians and support staff (e.g., medical assistants, front desk staff, accounting and billing, and other administrative staff) to increase clinical, counseling, and administrative capacity for providing the full range of contraceptive methods. This training included nearly all Title X clinics in the State of Delaware.

Evaluation of the Delaware Contraceptive Access Now Initiative: <https://popcenter.umd.edu/delcaneval/>

Oregon is another state incentivizing LARC use through the implementation of an incentive metric in the Medicaid program. Benchmark goals were set by the state as aspirational (but not required) goals for Coordinated Care Organizations (CCOs) to meet.<sup>48</sup> If quality metrics were met, CCOs would be eligible for a bonus equal to 4% of their total Medicaid Budget.<sup>48</sup> The Oregon initiative produced a 16.5% increase of effective contraceptive use, such as LARC methods, among women 18 to 24 years of age, and also showed an increase in contraceptive used among all Medicaid enrollees.<sup>48</sup>

States across the country have developed initiatives to increase access to LARCs and many have seen substantial success. Programs such as the Colorado Family Initiative, the St. Louis CHOICE Project, and DeICAN<sup>49,50</sup> serve as pillars of reference for states looking to address educational barriers for providers and patients, and a cascade of postpartum LARC policy changes have been seen across 45 states.

Continuation and sustainability of this progress depends on support from strong partnerships. Recognizing the mutual benefits that states piloting LARC initiatives can provide one another, the Association of State and Territorial Health Officials convenes 27 states and territories in the “Increasing Access to Contraception Learning Community”.<sup>51</sup> Here states can leverage and sustain existing partnerships, including with the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS) Maternal and Infant Health Initiative, and the Office of Population Affairs.<sup>51</sup> States seeking to improve contraceptive access and birth outcomes can find additional support with the CDC’s 6|18 initiative, which connects healthcare purchasers, payers, and providers with CDC researchers, economists, and policy analysts to find ways to improve health and control costs.<sup>52</sup>

## LARC & REPRODUCTIVE JUSTICE

It is important to present the outcomes of LARC promotion and incentive programs with the acknowledgement of implications on reproductive justice. Reproductive justice is defined as “the complete physical, mental, spiritual, political, economic, and social well-being of women and girls”.<sup>53</sup> It builds from the recognition that communities, specifically low-income communities of color, have experienced historical reproductive abuse. Leaders and advocates of LARC promotion efforts must be cognizant of these abuses, such as the eugenicist promotion of birth control in the early 20th century to U.S. sterilization laws affecting the disabled and poor women of color.<sup>53</sup> The history of contraceptive coercion and reproductive injustice contributes to current racial and ethnic differences in patterns of LARC use.<sup>54</sup>

Concerns for many Black women arise from the harmful history of eugenics and the use of contraceptives to control the fertility of vulnerable populations, and these concerns have resulted in widespread distrust of medical and public health institutions.<sup>55,56</sup> In reproductive healthcare there has been a long-standing paradox between some women’s lack of access to desired contraceptive care, such as LARC, and other’s experiences of discriminatory pressure to use those same methods. For example, in one randomized trial, clinicians were more likely to recommend IUDs to Latina and Black women of low socioeconomic status compared to their white peers.<sup>57</sup> This may be the result of unconscious biases or from “statistical discrimination”—a phenomenon where epidemiologic data are inappropriately applied to guide treatment decisions for individual patients.<sup>56</sup>

Clinical emphasis on LARC over all other methods, on the sole basis of efficacy, should not infringe on patient preference and choice or be coercive. Reproductive justice advocates call for putting the priorities, needs, and preferences of individual women first, and disallowing practices that impose a view of what contraceptive method is “best” for women. A shared decision-making approach between patient and provider can help women explore pregnancy intentions, contraceptive options, and improve their ability to make choices about their fertility. Providing early, patient-centered contraceptive counseling to all women, with sensitivity to the historical and cultural context of these interactions, is necessary to improve family planning outcomes.

## FUTURE RESEARCH NEEDED

Although a substantial body of research exists on LARC methods, future research could contribute to improving patient experiences and satisfaction. Further research on patient preferences and experiences could shed light on new or existing issues related to LARC provision. Additional research in this area is particularly important among younger populations, and teens, where LARC use has grown rapidly in recent years. Adolescents contribute the largest proportion of unintended pregnancies in the United States annually,<sup>4</sup> so additional information could illuminate key considerations to support the pregnancy desires of this group.

More research is also needed to assess impacts from policies like the contraceptive coverage mandate and of efforts by legislators to siphon Medicaid funds from planned parenthood or other providers that offer abortion services.<sup>58</sup> Impacts that can be demonstrated from policies like the contraceptive coverage mandate, such as changes in contraceptive access, utilization, and out-of-pocket costs, provide an important foundation for future policy decisions in these areas. Outcomes of legislative action can impact women's contraceptive choices, LARC uptake, and the unintended pregnancy rate, and therefore are important to study. Finally, communicating new research and information as LARC methods become more available is essential for ensuring patients and providers have adequate means to make informed decisions and choices pertaining to LARC.

Substantial momentum to increase widespread access and use of LARC can be seen at the federal (through the Affordable Care Act), state, and provider level. This has a huge potential to positively impact the health, economic, and social well-being of many women.<sup>59</sup> Approaching LARC promotion with a reproductive justice framework can also help guide states and providers to sustainable and ethical LARC provision.

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## REFERENCES:

1. Trussell J, Aiken ARA, Micks E, Guthrie KA. Efficacy, safety, and personal considerations. In: *Contraceptive Technology 21st Edition*. 21st edition. Ayer Company Publishers, Incorporated; 2018. <https://books.google.com/books?id=qsZ8tWECAAJ>
2. The American College of Obstetricians and Gynecologists. Long-Acting Reversible Contraception: Implants and Intrauterine Devices, Practice Bulletin 186. Published online November 2017. <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/11/long-acting-reversible-contraception-implants-and-intrauterine-devices>
3. Trussell J, Hassan F, Lowin J, Law A, Filonenko A. Achieving cost-neutrality with long-acting reversible contraceptive methods. *Contraception*. 2015;91(1):49-56. doi:10.1016/j.contraception.2014.08.011
4. Finer LB, Zolna MR. Declines in Unintended Pregnancy in the United States, 2008-2011. *N Engl J Med*. 2016;374(9):843-852. doi:10.1056/NEJMsa1506575
5. Trussell J, Vaughan B, Stanford J. Are all contraceptive failures unintended pregnancies? Evidence from the 1995 National Survey of Family Growth. *Fam Plann Perspect*. 1999;31(5):246-247, 260.
6. Potter JE, Stevenson AJ, Coleman-Minahan K, et al. Challenging unintended pregnancy as an indicator of reproductive autonomy. *Contraception*. 2019;100(1):1-4. doi:10.1016/j.contraception.2019.02.005
7. Kost K, Zolna M. Challenging unintended pregnancy as an indicator of reproductive autonomy: a response. *Contraception*. 2019;100(1):5-9. doi:10.1016/j.contraception.2019.04.010
8. United Nations, Department of Economic and Social Affairs, Population Division. *Contraceptive Use by Method 2019: Data Booklet (ST/ESA/SER.A/435)*. UN; 2019. doi:10.18356/1bd58a10-en
9. Daniels K, Abma J. Current Contraceptive Status Among Women Aged 15–49: United States, 2017–2019. 2020;(388):8. <https://www.cdc.gov/nchs/data/databriefs/db388-H.pdf>
10. Mosher WD, Westoff CF. *Trends in Contraceptive Practice: United States, 1965-76*. U.S. Department of Health and Human Services, Public Health Services Office of Health Research, Statistics, and Technology, National Center for Health Statistics; 1982. Accessed June 18, 2021. [https://www.cdc.gov/nchs/data/series/sr\\_23/sr23\\_010.pdf](https://www.cdc.gov/nchs/data/series/sr_23/sr23_010.pdf)
11. Horwitz R. The Dalkon Shield. The Embryo Project Encyclopedia. Published 2018. Accessed June 18, 2021. <https://embryo.asu.edu/pages/dalkon-shield>
12. Sonfield A. Popularity Disparity: Attitudes About the IUD in Europe and the United States. Guttmacher Policy Review. Published November 12, 2007. Accessed June 18, 2021. <https://www.guttmacher.org/gpr/2007/11/popularity-disparity-attitudes-about-iud-europe-and-united-states>
13. HRSA. *Women's Preventive Service Guidelines*.; 2016. <https://www.hrsa.gov/womens-guidelines-2016/index.html>
14. Kaitz M, Mankuta D, Mankuta L. Long-acting reversible contraception: A route to

- reproductive justice or injustice. *Infant Ment Health J.* 2019;40(5):673-689. doi:10.1002/imhj.21801
15. Bergin A, Tristan S, Terplan M, Gilliam ML, Whitaker AK. A missed opportunity for care: two-visit IUD insertion protocols inhibit placement. *Contraception.* 2012;86(6):694-697. doi:10.1016/j.contraception.2012.05.011
  16. Guttmacher Institute. *An Overview of Consent to Reproductive Health Services by Young People.*; 2020. <https://www.guttmacher.org/state-policy/explore/overview-minors-consent-law>
  17. White K, Hopkins K, Potter JE, Grossman D. Knowledge and attitudes about long-acting reversible contraception among Latina women who desire sterilization. *Womens Health Issues.* 2013;23(4):e257-263. doi:10.1016/j.whi.2013.05.001
  18. US Census Bureau. *Educational Attainment in the United States 2019.*; 2020. <https://www.census.gov/newsroom/press-releases/2020/educational-attainment.html>
  19. Meneses LM, Orrell-Valente JK, Guendelman SR, Oman D, Irwin CE. Racial/ethnic differences in mother-daughter communication about sex. *J Adolesc Health.* 2006;39(1):128-131. doi:10.1016/j.jadohealth.2005.08.005
  20. Harper CC, Stratton L, Raine TR, et al. Counseling and provision of long-acting reversible contraception in the US: national survey of nurse practitioners. *Prev Med.* 2013;57(6):883-888. doi:10.1016/j.ypmed.2013.10.005
  21. Foran T, Butcher BE, Kovacs G, Bateson D, O'Connor V. Safety of insertion of the copper IUD and LNG-IUS in nulliparous women: a systematic review. *Eur J Contracept Reprod Health Care.* 2018;23(5):379-386. doi:10.1080/13625187.2018.1526898
  22. Beeson T, Wood S, Bruen B, Goldberg DG, Mead H, Rosenbaum S. Accessibility of long-acting reversible contraceptives (LARCs) in Federally Qualified Health Centers (FQHCs). *Contraception.* 2014;89(2):91-96. doi:10.1016/j.contraception.2013.09.014
  23. Harper CC, Blum M, de Bocanegra HT, et al. Challenges in translating evidence to practice: the provision of intrauterine contraception. *Obstet Gynecol.* 2008;111(6):1359-1369. doi:10.1097/AOG.0b013e318173fd83
  24. Olson EM, Kramer RD, Gibson C, Wautlet CK, Schmuhl NB, Ehrental DB. Health Care Barriers to Provision of Long-Acting Reversible Contraception in Wisconsin. *WMJ.* 2018;117(4):149-155.
  25. Sobel L, Salganicoff A, Kurani N. Coverage of Contraceptive Services: A Review of Health Insurance Plans in Five States. KFF. Published April 16, 2015. Accessed June 18, 2021. <https://www.kff.org/private-insurance/report/coverage-of-contraceptive-services-a-review-of-health-insurance-plans-in-five-states/>
  26. Paul R, Bayer C, Braun E, Mullen M, Frisse A, Robbins CC. Immediate Postpartum LARC Reimbursement Increases Uptake of Effective Contraception After Pregnancy [22G]. *Obstetrics & Gynecology.* 2018;131:80S. doi:10.1097/01.AOG.0000533372.58870.87
  27. Liberty A, Yee K, Darney BG, Lopez-Defede A, Rodriguez MI. Coverage of immediate postpartum long-acting reversible contraception has improved birth intervals for at-risk populations. *Am J Obstet Gynecol.* 2020;222(4S):S886.e1-S886.e9. doi:10.1016/j.ajog.2019.11.1282



28. Liu Y, Hebert LE, Hasselbacher LA, Stulberg DB. "Am I Going to Be in Trouble for What I'm Doing?": Providing Contraceptive Care in Religious Health Care Systems. *Perspect Sex Reprod Health*. 2019;51(4):193-199. doi:10.1363/psrh.12125
29. Sobel L, Salganicoff A, Gomez I. State and Federal Contraceptive Coverage Requirements: Implications for Women and Employers. KFF. Published March 29, 2018. Accessed May 6, 2021. <https://www.kff.org/womens-health-policy/issue-brief/state-and-federal-contraceptive-coverage-requirements-implications-for-women-and-employers/>
30. Guttmacher Institute. Insurance Coverage of Contraceptives. Published online May 1, 2021. <https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives>
31. Tolbert J. The Coverage Provisions in the Affordable Care Act: An Update - Health Insurance Market Reforms. KFF. Published March 2, 2015. Accessed June 8, 2021. <https://www.kff.org/report-section/the-coverage-provisions-in-the-affordable-care-act-an-update-health-insurance-market-reforms/>
32. Kavanaugh ML, Pliskin E. Use of contraception among reproductive-aged women in the United States, 2014 and 2016. *F&S Reports*. 2020;1(2):83-93. doi:10.1016/j.xfre.2020.06.006
33. Kaiser Family Foundation. Status of State Medicaid Expansion Decisions: Interactive Map. KFF. Published June 7, 2021. Accessed June 18, 2021. <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>
34. MACPAC. *Medicaid Enrollment Changes Following the ACA*.; 2020. [https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/#\\_ftn1](https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/#_ftn1)
35. Walls J, Ranji U, Gomez I. Medicaid Coverage of Family Planning Benefits: Results from a State Survey. The Henry J. Kaiser Family Foundation. Published September 15, 2016. Accessed August 27, 2017. <http://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-results-from-a-state-survey/>
36. MACPAC. *Report to Congress on Medicaid and CHIP, June 2016*.; 2016. <https://www.macpac.gov/wp-content/uploads/2016/06/June-2016-Report-to-Congress-on-Medicaid-and-CHIP.pdf>
37. American College of Obstetricians and Gynecologists. Committee Opinion No. 666: Optimizing Postpartum Care. *Obstet Gynecol*. 2016;127(6):e187-e192. doi:10.1097/AOG.0000000000001487
38. Daw JR, Hatfield LA, Swartz K, Sommers BD. Women In The United States Experience High Rates Of Coverage 'Churn' In Months Before And After Childbirth. *Health Affairs*. 2017;36(4):598-606. doi:10.1377/hlthaff.2016.1241
39. Association of State and Territorial Health Officials. Long-Acting Reversible Contraception Payment and Reimbursement: Payment Strategies for Providers. Published online 2015. <https://www.astho.org/MCH/LARC/White-Bagging-Factsheet/>
40. Steenland MW, Pace LE, Sinaiko AD, Cohen JL. Medicaid Payments For Immediate Postpartum Long-Acting Reversible Contraception: Evidence From South Carolina. *Health Affairs*. 2021;40(2):334-342. doi:10.1377/hlthaff.2020.00254

41. McCaman E. Contraceptive Equity in Action: A Toolkit for State Implementation. National Health Law Program. Published July 2019. Accessed June 18, 2021. <https://healthlaw.org/resource/contraceptive-equity-in-action-a-toolkit-for-state-implementation/>
42. Gomez AM. Availability of Pharmacist-Prescribed Contraception in California, 2017. *JAMA*. 2017;318(22):2253. doi:10.1001/jama.2017.15674
43. Rodriguez MI, Anderson L, Edelman AB. Pharmacists Begin Prescribing Hormonal Contraception in Oregon: Implementation of House Bill 2879. *Obstet Gynecol*. 2016;128(1):168-170. doi:10.1097/AOG.0000000000001474
44. Ricketts S, Klingler G, Schwalberg R. Game Change in Colorado: Widespread Use Of Long-Acting Reversible Contraceptives and Rapid Decline in Births Among Young, Low-Income Women. *Perspectives on Sexual and Reproductive Health*. 2014;46(3):125-132. doi:10.1363/46e1714
45. Birgisson NE, Zhao Q, Secura GM, Madden T, Peipert JF. Preventing Unintended Pregnancy: The Contraceptive CHOICE Project in Review. *Journal of Women's Health*. 2015;24(5):349-353. doi:10.1089/jwh.2015.5191
46. Secura GM, Adams T, Buckel CM, Zhao Q, Peipert JF. Change in sexual behavior with provision of no-cost contraception. *Obstet Gynecol*. 2014;123(4):771-776. doi:10.1097/AOG.000000000000184
47. Illinois Department of Healthcare and Family Services. Illinois Family Planning Action Plan. Published online 2014. <https://www.illinois.gov/hfs/MedicalClients/FamilyPlanning/Pages/IllinoisFamilyPlanningActionPlan.aspx>
48. Rodriguez MI, Meath T, Huang J, Darney BG, McConnell KJ. Association of Implementing an Incentive Metric in the Oregon Medicaid Program With Effective Contraceptive Use. *JAMA Netw Open*. 2020;3(8):e2012540. doi:10.1001/jamanetworkopen.2020.12540
49. Choi YS, Rendall MS, Boudreaux M, Roby DH. Summary of the Delaware Contraceptive Access Now (DeCAN) Initiative. Published online May 2, 2019. <https://www.popcenter.umd.edu/delcaneval/summary-init>
50. Rendall MS. Evaluation of the Delaware Contraceptive Access Now Initiative. DeCAN Initiative Evaluation. Published November 6, 2019. Accessed September 1, 2020. <https://popcenter.umd.edu/delcaneval/evaluation>
51. Association of State and Territorial Health Officials. Building Partnerships to Support Long-Acting Reversible Contraception Programs. Published online 2017. Accessed June 18, 2021. <https://www.astho.org/Maternal-and-Child-Health/Increasing-Access-to-Contraception/Partnerships-for-LARC-Projects-Factsheet-PDF/>
52. *CDC's 6|18 Initiative, Accelerating Evidence into Action*. Centers for Disease Control and Prevention; 2018. Accessed December 2, 2018. <https://www.cdc.gov/sixeighteen/docs/6-18-factsheet.pdf>
53. Silliman J, Fried MG, Ross L, Gutiérrez E. *Undivided Rights: Women of Color Organizing for Reproductive Justice*. Second Edition. Haymarket Books; 2016. Accessed July 7, 2021. <https://www.haymarketbooks.org/books/917-undivided-rights>
54. Dehlendorf C, Rodriguez MI, Levy K, Borrero S, Steinauer J. Disparities in

Family Planning. *Am J Obstet Gynecol*. 2010;202(3):214-220.  
doi:10.1016/j.ajog.2009.08.022

55. Thorburn S, Bogart LM. Conspiracy beliefs about birth control: barriers to pregnancy prevention among African Americans of reproductive age. *Health Educ Behav*. 2005;32(4):474-487.  
doi:10.1177/1090198105276220
56. Gomez AM, Fuentes L, Allina A. Women or LARC First? Reproductive Autonomy And the Promotion of Long-Acting Reversible Contraceptive Methods. *Perspectives on Sexual and Reproductive Health*. 2014;46(3):171-175.  
doi:10.1363/46e1614
57. Dehlendorf C, Ruskin R, Grumbach K, et al. Recommendations for intrauterine contraception: a randomized trial of the effects of patients' race/ethnicity and socioeconomic status. *Am J Obstet Gynecol*. 2010;203(4):319.e1-8.  
doi:10.1016/j.ajog.2010.05.009
58. Family Research Council. Defunding Planned Parenthood and the Abortion Industry. Pro-Life Laws in the States. Published 2020. Accessed July 7, 2021. <https://frc.org/prolifemaps>
59. Trussell J, Henry N, Hassan F, Prezioso A, Law A, Filonenko A. Burden of unintended pregnancy in the United States: potential savings with increased use of long-acting reversible contraception. *Contraception*. 2013;87(2):154-161.  
doi:10.1016/j.contraception.2012.07.016