



EVIDENCE SUMMARY

Prevent Unintended Pregnancy

PROPOSED PAYER INTERVENTION

1 Reimburse providers for the full range of contraceptive services (e.g., screening for pregnancy intention; tiered contraception counseling; insertion, removal, replacement, or reinsertion of long-acting reversible contraceptives [LARC] or other contraceptive devices, and follow-up) for women of childbearing age.

2 Reimburse providers or provider systems for the actual cost of LARC or other contraceptive devices in order to provide the full range of contraceptive methods.

WHAT IS CDC'S 6|18 INITIATIVE?

The CDC is partnering with health care purchasers, payers, and providers to improve health and control health care costs. CDC provides these partners with rigorous evidence about high-burden health conditions and associated interventions to inform their decisions to have the greatest health and cost impact. This initiative aligns evidence-based preventive practices with emerging value-based payment and delivery models.

WHO'S AT RISK?

- Women of childbearing age, particularly adolescents (aged 15-19 years) and young women (aged 20-24 years)
- Approximately 50% of pregnancies are unintended. Higher proportions of unintended pregnancies occur among the following groups: adolescents and young women, women who are of racial or ethnic minorities, and women with lower levels of education and income.¹
- Potential implications to payers: Unintended pregnancies increase the risk for poor maternal and infant outcomes,^{2,3} and in 2010, resulted in \$21 billion in direct medical costs in the United States.⁴



OPPORTUNITIES FOR PAYERS AND PROVIDERS

Payers and providers can explore options to promote patient and provider awareness that access to all 18 contraceptive methods is available, without cost-sharing, under a state’s approved Medicaid plan, section 1115 family planning demonstration, or family planning state plan option.

Payers can explore options to improve patient and provider awareness that non-grandfathered plans and insurers must cover at least one form of contraception within each of the 18 FDA-approved methods of contraception—without cost-sharing.

Payers can explore options to reimburse providers at rates that, at a minimum, cover the actual cost of the contraceptive method and/or services. This is particularly important when IUDs and/or implants are requested by a patient, since these methods can have high up-front costs relative to other contraceptive methods, but are very cost-effective over the life of the device.



KEY HEALTH AND COST EVIDENCE MESSAGES FOR PAYERS AND PROVIDERS

Without public funding for family planning services, the numbers and rates of unintended pregnancies and abortions in the United States could be nearly 50% higher than current levels. Public-sector funding for family planning programs has been shown to save money on maternity and infant care by preventing unplanned births.^{5,6}

Payers may generate health care cost savings and can reduce contraceptive non-adherence by increasing patients’ access to the use of LARC. When patients are not able to take contraceptive medications as directed (contraceptive adherence), many unintended pregnancies and avoidable high costs may result.⁷

CURRENT PAYER COVERAGE (AS OF AUGUST 2015)

MEDICARE

- ✓ N/A

MEDICAID

- ✓ Medicaid must pay for contraceptive and family planning services. Beneficiaries are free to choose the method of family planning services, without coercion or mental pressure from payers or providers.
- ✓ Family planning services are exempt from cost-sharing.⁸ Individuals have access to all contraceptive methods available under a state’s approved Medicaid plan, section 1115 family planning demonstration, or family planning state plan option without any cost-sharing.

COMMERCIAL/PRIVATE

- ✓ Non-grandfathered plans and insurers must cover, without cost-sharing, at least one form of contraception within each of the 18 methods of contraception that the FDA has identified for women.
- ✓ If an item or service is not covered but is determined medically necessary, an easily accessible process for the woman to get that item or service is required.
- ✓ Recommended preventive services for women (such as preconception and prenatal care) are also covered for dependent children as well (i.e., not just parents on the plan).
- ✓ Insurance companies may still use reasonable medical management techniques within each of the methods of contraception.

SUPPORTING HEALTH AND COST EVIDENCE: SCIENCE BEHIND THE ISSUE

Nationally, 51% of all U.S. births in 2010 were paid for by public insurance through Medicaid, the Children's Health Insurance Program and the Indian Health Service. Two million births were publicly funded in 2010; of those, about half—one million—were unplanned. A publicly funded birth in 2010 cost an average of \$12,770 in prenatal care, labor and delivery, postpartum care and 12 months of infant care; when 60 months of care are included, the cost per birth increases to \$20,716. Government expenditures on the births, abortions and miscarriages resulting from unintended pregnancies nationwide totaled \$21 billion in 2010; that amounts to 51% of the \$40.8 billion spent for all publicly funded pregnancies that year. The total gross potential savings from averting all unintended pregnancies in 2010 would have been \$15.5 billion. This is less than the total public cost of all unintended pregnancies, because even if all women had been able to time their pregnancies as they wanted, some of the resulting births still would have been publicly funded. These potential savings do not account for the public investment in family planning services and other interventions that might be required to achieve them.⁹



Decision-making around contraceptive use is complex and influenced by patient, provider, and health system factors, including cost. Understanding the potential impact of eliminating cost-sharing on contraceptive use patterns among privately insured women nationally is important for clinicians, policymakers, and insurers. A study on the relationship between out-of-pocket costs and LARC use among women who had employer-sponsored insurance plans found that women in plans with the highest cost-sharing levels were 35% less likely to receive IUDs compared with women in plans with the lowest cost-sharing levels. Rates of IUD initiation among women with employer-sponsored health insurance were higher when cost-sharing was lower, even after accounting for cost-sharing levels of other contraceptive methods under a given plan. Although it is generally more expensive to initiate an IUD or implant than a short-acting contraceptive method, over time, LARC methods (which can remain in place for 3 to 10 years) may be far more cost-effective both in terms of medication costs and unintended pregnancies averted.¹⁰



A three-state economic model was developed to estimate the relative costs of no method (chance), four short-acting reversible methods, and three LARC methods. Even if LARC methods are not used for their full durations of efficacy, they become cost-saving relative to short-acting contraceptive methods within three years of use. Costs associated with drug acquisition, administration and failure (defined as an unintended pregnancy) were considered. Key topics modeled were the annual average cost per method and the minimum duration of LARC usage in order to achieve cost savings compared to the short-acting reversible methods. This study calculated that cost-savings from LARC methods—relative to short-acting methods, with discontinuation rates considered—can be realized within 3 years.¹¹



The proportion of births resulting from unintended pregnancies that were publicly funded varied by state, from 42% to 81%. Of the 2 million publicly funded births, 51% resulted from unintended pregnancies, accounting for \$11.1 billion in costs—half of the total public expenditures on births. In seven states, the costs for births from unintended pregnancies exceeded a half-billion dollars. Reductions in the public costs from the current level of \$11.1 billion would translate to gross savings for the federal and state governments. Uncounted in that \$11.1 billion are costs from the increased likelihood of preterm birth, low birth weight and other negative perinatal outcomes; children's medical care beyond their first year; pregnancy-related care paid for by other government-related health programs, including the Indian Health Service and indigent care programs that subsidize hospitals' uncompensated care; and other government benefits, such as food stamps and welfare payments.¹²



For every public dollar spent on pregnancy prevention, \$4.02 was shown to be saved on maternity and infant care among Medicaid-eligible women whose unintended pregnancies were prevented. A 2003 national survey representing women of reproductive age showed that an estimated \$15.7 billion was saved over one year by preventing unplanned births.¹³



In 2010, public-sector investments in family planning programs resulted in net government savings of \$13.6 billion, or a savings of \$7.09 for every public dollar spent.¹⁴ Care provided during publicly supported family planning visits averted an estimated 2.2 million unintended pregnancies, including 287,500 closely spaced and 164,190 preterm or low birth weight births, and 13,170 cases of pelvic inflammatory disease that would have led to 1,130 ectopic pregnancies and 2,210 cases of infertility. Approximately \$15.7 billion was saved from preventing unintended pregnancies, \$123 million from sexually transmitted infections/HIV testing, and \$23 million from Pap and HPV testing and vaccines. Subtracting \$2.2 billion in program costs from gross savings resulted in net public-sector savings of \$13.6 billion.



Contraceptives that are incorrectly or inconsistently used may lead to unintended pregnancies and avoidable high costs. Because LARC requires no user effort after insertion, the potential for inconsistent use is eliminated. Improved use of LARC among women aged 15-44 may generate health-care cost savings by reducing inconsistent contraceptive use. If 10% of women aged 20-29 years switched from oral contraception to LARC, total health-sector costs would be reduced by \$288 million per year.¹⁵ LARC use can be increased by effective patient-centered counseling and access to LARC devices during family planning counseling visits. Of 1500 women enrolled in a cluster randomized trial in 40 reproductive health clinics across the USA in 2011-2013, more women at intervention than control sites reported receiving counseling on IUDs or implants (565 [71%] of 797 vs. 271 [39%] of 693), and more selected LARCs during the clinic visit (224 [28%] vs. 117 [17%]). Providers in the intervention group received LARC training; LARC billing assistance with usual costs for contraception was maintained at study sites to test the intervention under real-life conditions. The pregnancy rate was lower in the intervention group than in the control group after family planning visits but not after abortion visits. Researchers found that the pregnancy incidence among participants was significantly reduced by nearly half among participants attending family planning visits, which is in contrast to findings in previous randomized trials.¹⁶



Offering LARC methods to clients at no cost in Colorado Title X-funded clinics, compared with offering all other methods on a sliding-fee scale, resulted in a 19% increase in use of LARC among 15- to 24-year-olds between 2008-2011; 29% decrease in fertility rates among 15- to 19-year-olds and 14% decrease among 20- to 24-year-olds between 2007-2011; 24% decrease in high-risk births among all births between 2009-2011; 34% decrease in abortion rates among 15- to 19-year-olds and 18% among 20- to 24-year-olds between 2008-2011; and 23% decreased enrollment in the Women, Infants, and Children (WIC) program statewide from 2007-2010.¹⁷ Participants ages 14 to 45 were educated about reversible contraception (with an emphasis on the benefits of LARC methods), were given their choice of reversible contraception at no cost, and were then followed for 2 to 3 years. Rate results for this study (the Contraceptive CHOICE project) were pregnancy, 34.0/1000; birth, 19.4/1000; abortion, 9.7/1000. This was compared to 2008 U.S. active teen rates of pregnancy: 158.5/1000; birth: 94.0/1000; abortion: 41.7/1000.¹⁸

PROPOSED PAYER INTERVENTION

3 Reimburse for immediate postpartum insertion of long-acting reversible contraceptives (LARC) by unbundling payment for LARC from other postpartum services.

WHO'S AT RISK?

- Postpartum women
- Unintended pregnancy carries significant health and economic consequences and disproportionately affects poor women and women of color.^{19,20} Rapid repeat pregnancy—defined as pregnancy within 12 to 18 months after delivery—can occur if women are unsuccessful at initiating contraception shortly after delivery.²¹



OPPORTUNITIES FOR PAYERS AND PROVIDERS

Improving postpartum initiation of effective contraception, including LARC, is a key strategy to reduce unintended pregnancy and health inequities. Policy changes that include reimbursement for postpartum LARC placement, LARC devices and the immediate insertion procedure during hospital admission for birth are essential strategies to improve LARC access, reduce unintended pregnancy and reduce rapid, repeat pregnancy rates.²²

Payers can include reimbursement for additional costs associated with provision of LARC so that they can be reimbursed outside of the single prospective payments for labor and delivery services when the procedure is performed while the woman is still in the hospital after delivery. If the costs of LARC are not unbundled from the global delivery fee, providers may have a strong financial disincentive to offer LARC in this context.

Payers can include reimbursement to either the hospital or the provider for counseling/education in the prenatal and postpartum period, the actual cost of the IUD or implant device, as well as insertion, replacement or reinsertion of expelled IUDs inserted immediately postpartum.



KEY HEALTH AND COST EVIDENCE MESSAGES FOR PAYERS AND PROVIDERS

Although immediate postpartum LARC placement is not (as of August 2015) a widespread practice, immediate postpartum placement demonstrates potential for improved health and cost savings (in terms of averted unintended pregnancies).²³ The reasons cited for low rates of LARC use in the immediate postpartum period are the inability to be reimbursed for the devices outside of the bundled fee for delivery, high up-front costs of devices, and payment policies that either reduce (or do not provide) reimbursement for devices or placement. Changes in billing policy such as coding modifiers to allow reimbursement for the LARC devices have been successful in at least 13 states as of July 2015 (California, Colorado, Georgia, Illinois, Indiana, Iowa, Louisiana, Maryland, Montana, New Mexico, New York, Oklahoma, and South Carolina) to increase patient access to LARC and decrease rates of rapid, repeat pregnancies.²⁴

CURRENT PAYER COVERAGE (AS OF AUGUST 2015)

MEDICARE

- ✓ N/A

MEDICAID

- ✓ Family planning services and supplies are a mandatory benefit under the traditional coverage offered by each state's Medicaid plan.
- ✓ Beneficiaries are free to choose the method of family planning services, without coercion or mental pressure.
- ✓ Family planning services are exempt from cost-sharing.²⁵ Individuals have access to all contraceptive methods available under a state's approved Medicaid plan, section 1115 family planning demonstration, or family planning state plan option without any cost-sharing.

COMMERCIAL/PRIVATE

- ✓ All non-grandfathered plans and insurers must cover, without cost-sharing, at least one form of contraception within each of the 18 methods of contraception that the FDA has identified for women.
- ✓ If an item or service is not covered but is determined medically necessary, an easily accessible process for the woman to get that item or service is required.
- ✓ Recommended preventive services for women (such as preconception and prenatal care) are covered for the dependent children (i.e., not just the parents on the plan).
- ✓ Insurance companies may still use reasonable medical management techniques within each of the methods of contraception (there are currently 18 identified by the FDA for women).

SUPPORTING HEALTH AND COST EVIDENCE: SCIENCE BEHIND THE ISSUE

Immediate postpartum LARC placement averted more than 88 unintended pregnancies per 1,000 women over 2 years, saving ~\$282,540 per 1,000 women over 2 years and more than \$3,200 for each unintended pregnancy.²⁶ Short inter-pregnancy intervals are associated with increased risk for preterm birth, low birth weight, small for gestational age, and perinatal death.²⁷ Publicly funded postpartum contraception can extend inter-pregnancy intervals. Among adolescents who delivered at the University of Colorado Hospital over 18 months from June 2008 to November 2009, pregnancy rates at 6, 12, 24, and 36 months postpartum were significantly higher in the comparison group than in the immediate postpartum implant (IPI) group. At 12, 24, and 36 months, publicly funded IPIs would save more than \$550,000, \$2.5 million, and \$4.5 million, respectively. For every dollar spent on the IPI program, \$0.79, \$3.54, and \$6.50 would be saved at 12, 24, and 36 months.²⁸

PROPOSED PAYER INTERVENTION

4

Remove administrative and logistical barriers to long-acting reversible contraceptives (LARC) (e.g., remove pre-approval requirement or step therapy restriction and manage high acquisition and stocking costs).

WHO'S AT RISK?

- Women of childbearing age who choose LARC as their contraceptive method to prevent unintended pregnancy, but are faced with barriers for obtaining LARC.
- Potential implications to payers: Clinic or provider protocols that do not allow women to receive same-day LARC insertion²⁹ may require authorization prior to the procedure,³⁰ or require a woman to first try and fail on another contraceptive method,³¹ may result in many women being lost to follow-up and placed at risk of an unintended pregnancy.



OPPORTUNITIES FOR PAYERS AND PROVIDERS

Health-care provider continuing education and training are needed to increase same-day LARC insertion to reduce barriers and increase LARC use, including immediately following miscarriage, abortion, and vaginal or cesarean delivery. Payers and providers can work to improve provider awareness of recommendations such as the 2009 American College of Obstetricians and Gynecologists (ACOG) Opinion Statement, which recommends the adoption of same-day LARC insertion protocols and suggests options to reduce the up-front costs of LARC devices.³²

Payers can take steps to help providers address high up-front costs of LARC. Successful examples in states such as South Carolina and Texas include establishing a replacement program that enables providers to obtain LARC devices without having to absorb acquisition and stocking costs. This can be accomplished through a direct payment arrangement between the state agency and its pharmacies.

Payers can create policies that do not require LARC contraceptive method prior authorization, multiple provider visits, or require failure of other contraceptive methods before LARC can be offered.

Payer and provider leaders can revise staffing protocols and identify billing codes that can support increased LARC use by providers.



KEY HEALTH AND COST EVIDENCE MESSAGES FOR PAYERS AND PROVIDERS

High unintended pregnancy rates in the United States may in part be the result of relatively low use of LARC methods. Healthcare providers' knowledge and skills related to LARC can be improved by increasing access to evidence-based continuing education on LARC in order to improve practice and incorrect perceptions of appropriate candidates for LARC use.

LARC methods require no effort after insertion, and can prevent unintended pregnancy for at least 3 to 10 years, depending on the type of LARC.³³ LARC methods are safe and have high acceptability³⁴ and continuation rates among women and teens.³⁵ LARC methods have few contraindications, and almost all women are eligible for implants and intrauterine devices.³⁶ Payers and health-care providers can support patient counseling on all contraceptive methods, including IUDs and implants, even if the patient initially states a preference for a specific contraceptive method.

Increasing opportunities for women to access LARC methods in the primary care, post-abortion, and postpartum setting can be achieved by addressing health-care system, provider, and patient barriers. Working with hospital billing departments and local health departments can provide options to address reimbursement coverage for providing LARC devices during inpatient stays.³⁷

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SUPPORTING HEALTH AND COST EVIDENCE: SCIENCE BEHIND THE ISSUE

Despite the 2009 ACOG recommendation, relatively few LARC are inserted on a same-day basis. A study examining obstetrician-gynecologists' practices and opinions about the use of IUDs in adolescents, nulliparous women and other patient groups reported that almost all obstetrician-gynecologists (95.8%) reported providing IUDs, but only 66.8% considered nulliparous women, and 43% considered adolescents appropriate candidates. 87% of ob-gyns reported that they require two or more visits for IUD insertion. A total of 67.3% of respondents agreed that an IUD can be inserted immediately after an abortion or miscarriage. Fewer (43.5%) agreed that an IUD can be inserted immediately postpartum, and very few provide these services (11.4% and 7.2%, respectively). Most of the respondents identified ACOG recommendations and continuing education as their most important source for staying informed about advances in clinical practice; therefore, wider dissemination of and training on current evidence-based recommendations may increase obstetrician-gynecologists' provision of IUDs.³⁹



Clinicians' attitudes about LARC, or the extent to which the recommendation to offer same-day insertions for LARC is applied in practice, was examined in 47 family planning agencies in Colorado and Iowa. Results indicated that agencies required fewer visits for the contraceptive implant than for the intrauterine device (IUD). Years of experience and professional title significantly predicted attitudes about the number of visits required to get LARC.⁴⁰



A review of opportunities to identify options to integrate LARC into comprehensive reproductive services identified billing considerations that allow for reimbursement of specific services or medical therapies.

Inclusion of topics such as factor VII, blood transfusions, or IUDs and implants can make a difference in reimbursement coverage for providing LARC devices during inpatient stays. Several states (California, New Mexico, New York, and South Carolina) have been successful in influencing their state Medicaid offices to cover LARC devices in the postpartum period during the inpatient stay. This process can begin by contacting the hospital's billing department regarding a separate billing code for LARC devices during inpatient stays. This review identified billing adjustments fixes such as a "flag" in the billing code or electronic medical record that signals separate billing.⁴¹

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