

Editorial

Global fee prohibits postpartum provision of the most effective reversible contraceptives[☆]

Early postpartum access to highly effective reversible contraceptives [intrauterine contraceptives (IUCs) and the implant] and sterilization is key to helping women prevent unintended pregnancy [1]. However, most current hospital reimbursement policies deny postpartum women access to IUCs and implants prior to hospital discharge. For women whose deliveries are covered by private insurance or Medicaid, hospitals receive a global fee based on the diagnosis-related group (DRG) for all delivery-related care. Postpartum sterilization is carved out by insurance companies and Medicaid as a procedure that may be billed separately from the global fee, which in turn means that hospitals are not financially driven to deny such procedures. In contrast, in most states, postpartum IUCs and implants are not carved out for separate reimbursement and the costs of the devices must be deducted from the DRG payment. Since the wholesale acquisition costs for IUCs and implants range from US\$600 to US\$775, covering those costs would be fiscally rash. Consequently, most hospitals do not permit postpartum placement of the most effective reversible methods, a policy that not only hinders women's ability to space their pregnancies but also prohibits an important option for those who have completed childbearing but do not wish to be sterilized. Equally, for women who are covered by Medicaid and desire postpartum sterilization, the twin requirements of a minimum 30-day waiting period after signing the consent form and having that form present in the delivery room still inhibit access [2]. For these women, postpartum placement of IUCs and implants would be a valuable alternative. Although the Affordable Care Act may go a long way toward expanding outpatient access to the most effective methods of contraception, it does not

specifically facilitate inpatient access to IUC or the implant for new mothers prior to hospital discharge.

Placement of IUCs immediately after placental delivery or an implant before hospital discharge is attractive because motivation to use is high, timing is convenient for the woman and provider and the woman is obviously known not to be pregnant. As Rodriguez et al. extensively document in their Commentary in this issue, postpartum placement of these products is also safe for the woman and there are no adverse effects on breastfeeding [3]. (However, we note that, in one study, women in whom the levonorgestrel IUC was placed immediately postpartum were more likely to discontinue breastfeeding than were mothers who delayed placement until 6–8 weeks postpartum [4].) There is also good evidence of high continuation rates at 6 and 12 months following immediate IUC placement [5–7] and of a reduction in the likelihood of repeat pregnancy within 24 months following placement of implants prior to discharge [8].

Perhaps the most compelling reason to provide highly effective reversible contraceptives to new mothers prior to hospital discharge is that women themselves want to use them but often face significant barriers to access. In their article in this issue, Potter et al. demonstrated substantial unmet demand for postpartum IUCs and implants. Thirty-four percent of women desired either an IUC or implant (a further 44% desired female or male sterilization), yet only 13% were using IUCs or the implants at 6 months postpartum. Among women who desired an IUC or implant and who wanted more children, 48% ended up using a method as or less effective than condoms at 6 months postdelivery [9].

In addition to improving women's health, a major advantage of facilitating postpartum placement of IUCs and implants is the potential to save money by preventing unintended births. The reason is that IUCs and implants are the most effective reversible contraceptives; they are in the top-tier effectiveness category [10] because they require no adherence on the part of the woman. Significant cost savings to the Colorado Medicaid program were demonstrated for adolescent mothers receiving postpartum implants: US\$0.78, US\$3.54 and US\$6.50 per dollar spent at 12, 24 and 36 months postpartum [11]. Likewise, immediate postpartum placement of IUCs in women covered by Emergency Medicaid (for undocumented immigrants and legal

[☆] Author Disclosures: ARAA: none. MDC: Consultant for Merck and receives research support from Medicines360 and Merck. AMK: The Department of Obstetrics and Gynecology at the University of Florida College of Medicine–Jacksonville receives research funds from Bayer and Teva. Dr. Kaunitz is a member of Actavis, Bayer, Merck and Teva advisory boards. ALN: Dr. Nelson is a consultant or advisory board member for Actavis, Bayer, ContraMed, Medicus, Merck, MicroCHIPS, Pharmanest and Teva and is on the speakers bureau for Actavis, Bayer, Merck, Pfizer and Teva. She receives research support from Bayer, Merck, Pfizer and Teva. JT: Consultant to Bayer and is a member of Merck and Teva advisory boards.

immigrants with less than 5 years of legal residence) in one Oregon hospital was estimated to save US\$3 for every dollar spent [12]. That hospital lost money on women whose obstetrical care was covered by Emergency Medicaid; thus, in theory, it might save money by preventing further such losses. However, in fact, it would not save money by using its own funds to cover postpartum IUCs because too few of these women return to it for subsequent obstetrical care.

There are of course other obstacles to providing immediate postpartum intrauterine devices and implants to women who are suitable candidates. Catholic hospitals, which provide one-sixth of hospital beds in the United States, do not allow placement of IUCs or implants for contraception. Other difficulties include ensuring an adequate stock of devices, the need for provider training and the task of coordinating a sufficient volume of skilled providers to be available when required. However, without the ability for hospitals to bill for postpartum placement separately from the global fee, there is no incentive for these issues to be addressed.

Separate billing for postpartum implants and IUCs for women covered by Medicaid is now permitted in 9 states (Colorado, Georgia, Iowa, Louisiana, Mississippi, New Mexico, New York, Oklahoma, and South Carolina). No legislative action is needed, just regulatory changes and short-term investments [3]. If this progressive Medicaid policy is adopted in all other states and should private insurance plans as well as Emergency Medicaid allow separate billing for postpartum IUCs and implants, women and their families will benefit from fewer unintended pregnancies, and health care dollars will be saved.

Abigail R.A. Aiken
Office of Population Research
Princeton University, Princeton, NJ, USA
 Corresponding author. Wallace Hall
 Princeton University, Princeton, NJ, 08544, USA
E-mail address: aaiken@princeton.edu

Mitchell D. Creinin
Department of Obstetrics and Gynecology
University of California, Davis, Sacramento, CA, USA

Andrew M. Kaunitz
Department of Obstetrics and Gynecology
University of Florida College of Medicine–Jacksonville
Jacksonville, FL, USA

Anita L. Nelson
Department of Obstetrics and Gynecology
David Geffen School of Medicine at the University of
California, Los Angeles, Los Angeles, CA, USA

James Trussell
Office of Population Research
Princeton University, Princeton, NJ, USA

References

- [1] Teal SB. Postpartum contraception: optimizing interpregnancy intervals. *Contraception* 2014;89:487–8.
- [2] Borrero S, Zite N, Potter JE, Trussell J. Medicaid policy on sterilization — anachronistic or still relevant? *N Engl J Med* 2014;370:102–4.
- [3] Rodriguez MI, Evans M, Espey E. Advocating for immediate postpartum LARC: increasing access, improving outcomes, and decreasing cost. *Contraception* 2014 in press. Available online at <http://www.sciencedirect.com/science/journal/aip/00107824>.
- [4] Chen BA, Reeves MF, Creinin MD, Schwarz EB. Postplacental or delayed levonorgestrel intrauterine device insertion and breast-feeding duration. *Contraception* 2011;84:499–504.
- [5] Chen BA, Reeves MF, Hayes JL, Hohmann HL, Perriera LK, Creinin MD. Postplacental or delayed insertion of the levonorgestrel intrauterine device after vaginal delivery: a randomized controlled trial. *Obstet Gynecol* 2010;116:1079–87.
- [6] Celen S, Möröy P, Sucak A, Aktulay A, Danişman N. Clinical outcomes of early postplacental insertion of intrauterine contraceptive devices. *Contraception* 2004;69:279–82.
- [7] Whitaker AK, Endres LK, Mistretta SQ, Gilliam ML. Postplacental insertion of the levonorgestrel intrauterine device after cesarean delivery vs. delayed insertion: a randomized controlled trial. *Contraception* 2014;89:534–9.
- [8] Tocce KM, Sheeder JL, Teal SB. Rapid repeat pregnancy in adolescents: do immediate postpartum contraceptive implants make a difference? *Am J Obstet Gynecol* 2012;206:481.e1–7.
- [9] Potter JE, Hopkins K, Aiken AR, Lopez CH, Stevenson AJ, White K, Grossman D. Unmet demand for highly effective postpartum contraception in Texas. *Contraception* 2014 in press. Available online at <http://www.sciencedirect.com/science/journal/aip/00107824>.
- [10] Trussell J, Guthrie KA. Choosing a contraceptive: efficacy, safety, and personal considerations. In: Hatcher RA, Trussell J, Nelson AL, Cates W, Kowal D, & Policar M, editors. *Contraceptive Technology: Twentieth*. New York NY: Ardent Media; 2011, pp. 45–74.
- [11] Han L, Teal SB, Sheeder J. Preventing repeat pregnancy in adolescents: is immediate postpartum insertion of the contraceptive implant cost effective? *Am J Obstet Gynecol* 2014;211:24.e1–7.
- [12] Rodriguez MI, Caughey AB, Edelman A, Darney PD, Foster DG. Cost-benefit analysis of state- and hospital-funded postpartum intrauterine contraception at a university hospital for recent immigrants to the United States. *Contraception* 2010;81:304–8.