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Inpatient Postpartum Long-Acting Reversible Contraception: Care That Promotes Reproductive Justice

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Abstract

Inpatient insertion of long-acting reversible contraceptives (LARC) (intrauterine devices and implants) is increasingly offered to women immediately after childbirth. Enthusiasm for this approach stems from robust safety, effectiveness, and cost-effectiveness data, and responsiveness to women's needs and preferences. While clinical evidence for immediate postpartum LARC is well-established, the ethical implications of enhancing access to this care have not been fully considered. Contraceptive policies and practices often embody a tension between fostering liberal availability and potentially coercive promotion of some methods. Historical contraceptive policies and contemporary disparities in LARC use point to the need to consider if health policies and health care practices support all women's reproductive wishes. Immediate postpartum LARC services need to be designed and implemented with the goal of ensuring autonomy and equity in postpartum contraceptive care. To this end, these services should include strategic plans to promote universal availability, prevent coercion, and enable device removal.

THE PROMISE OF IMMEDIATE POSTPARTUM CONTRACEPTIVE CARE

Timely access to contraception is essential after childbirth. Contraception reduces both unintended and closely spaced pregnancies, thereby improving maternal-child health outcomes.¹ Contraception also meets many women's preferences, with cohort studies suggesting that at least 75% of recently pregnant women in the United States want to delay or prevent childbearing, and up to 40% want to use long-acting reversible contraception (LARC).^{2,3}

Immediate postpartum LARC refers to the insertion of a contraceptive implant or intrauterine device while a woman is hospitalized for delivery. The American College of

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Obstetricians and Gynecologists and the Centers for Disease Control and Prevention endorse this approach as safe and effective.^{1,4}

Until recently, however, LARC placement during the delivery hospitalization was rare (13.5 per 10,000 deliveries in the United States in 2013).⁵ Instead, most LARC devices were placed 4–8 weeks after delivery (“interval” placement) in the outpatient setting. However, postpartum office visits are under-attended: roughly 40% of women do not receive outpatient postpartum care, often due to transportation, childcare, and employment obligations.¹ Even when women do return, they may have already resumed sexual activity and conceived prior to outpatient postpartum follow-up.¹ Moreover, nearly half of all delivering women experience a period of uninsurance in the six months after delivery, and may face financial barriers to LARC placement.⁶

Given limitations of interval LARC insertion, immediate postpartum LARC insertion has distinct advantages.⁷ For one, patients are known not to be pregnant. Inpatient insertion is convenient for many women.³ It enables intrauterine device (IUD) placement with the option of regional anesthesia. It is safe and does not increase risk of infection, uterine perforation, prolonged postpartum bleeding, or breastfeeding difficulties.^{1,4} From a public health perspective, immediate postpartum LARC insertion is associated with more healthy birth spacing compared to interval insertion.⁸ Finally, immediate postpartum placement can result in potential savings for payers and healthcare systems.¹ For all these reasons, we and others have argued for enhancing access to immediate postpartum LARC placement for interested women.^{7,9,10}

However, until 2012, most state Medicaid programs provided a single, bundled payment for all care during the delivery hospitalization. This episode payment did not increase to cover the cost of LARC-related care. Because LARC devices are expensive and Medicaid pays for nearly half of deliveries in the United States, providers’ inability to receive separate payment for LARC placement in the inpatient setting acted as a significant barrier to implementation. Since 2012, 28 state Medicaid agencies have begun providing separate payment or additional bundled payment when LARC devices are provided during the delivery hospitalization.¹¹ These changes in reimbursement, along with national practice guidelines emphasizing the safety and effectiveness of immediate postpartum LARC, have created new opportunities for this care. While clinical implementation barriers still exist—such as inadequate provider training and difficulty with device supply chain and billing—many clinicians, hospitals, and public health experts are striving to overcome such challenges and enhance postpartum LARC access.^{7,12}

REASONS FOR CAUTION ABOUT IMMEDIATE POSTPARTUM CONTRACEPTION

Although the importance of universal postpartum LARC access is recognized, enthusiasm must be balanced by considerations of what this approach means for individual women’s reproductive autonomy—and for a broader vision of reproductive justice. Advocates define “reproductive justice” as the right to limit fertility, to have children, and to parent with dignity and needed resources.¹² In this framework, contraceptive policies and care should

enable all women to either limit fertility or pursue pregnancy and parenthood according to their own wishes.¹² ACOG's Committee on Ethics has endorsed the use of this framework,¹³ as it can guide the design of contraceptive policies and practices that promote access, while also safeguarding against coercion. Three issues underscore the critical importance of adopting a reproductive justice framework for immediate postpartum LARC policies and services:

First, in reproductive healthcare, there is a long-standing tension between some women's lack of access to desired contraceptive care and others' experiences of discriminatory or coercive overuse of those same methods. Medical historians and ethicists have pointed to an ideology of "stratified reproduction" as underpinning this tension. "Stratified reproduction" refers to the idea that some people's fertility and childbearing are more valued than others'.¹⁴ In the United States, historical policies and practices prized and promoted reproduction in middle class and affluent white women, while discouraging or preventing reproduction in poor women, women of color, and other disadvantaged or marginalized women. The best known example of this is of course sterilization: poor and disabled women were sterilized without their knowledge or consent, while many affluent women could not obtain desired sterilizations.^{14,15}

While sterilizations are particularly egregious examples of this tension, some contemporary LARC practices may reflect this tension as well. For example, many clinicians participate in private donor-sponsored programs that provide free LARC devices to women without insurance. While such programs fill a critical access gap for uninsured women, they generally do not also provide free short-acting contraceptive methods. Thus, women with limited financial means may "choose" LARC in the context of highly restricted family planning options, if not outright pressure. Furthermore, to date, these programs have not included provisions for free LARC removal. Therefore, women who participate in the programs who then desire pregnancy or device removal for other reasons face additional obstacles compared to their insured counterparts.

Second, evidence also suggests that contemporary contraception provision differs based on a patient's race/ethnicity and class. Clinicians appear more likely to recommend IUDs to Latina and Black women of low socioeconomic status, compared to their white peers.¹⁶ Reasons for this variation remain unclear, but may be related to providers' assumptions about the need for/appropriateness of IUD use in different groups. In turn, these assumptions may stem from a range of unconscious biases or from the phenomenon of "statistical discrimination," in which epidemiologic data (in this case, data about unintended pregnancy risk) are inappropriately applied to guide treatment decisions for an individual patient.¹⁶ In one cohort of postpartum, low-income African American and Hispanic women, one-third reported feeling coerced or perceived racially-based discrimination in their contraceptive counseling.¹⁷ Such findings point to the need to ensure that sociodemographic characteristics do not interfere with any individual patient receiving her preferred contraceptive method.

Finally, there are documented socioeconomic differences in current postpartum contraceptive use. Recent national estimates suggest that both immediate postpartum

sterilization and LARC insertion are significantly more likely among poorer women, with a widening gap in immediate postpartum LARC use in recent years.⁵ Nationally from 2008–2013, women without private insurance received 57% of inpatient postpartum sterilizations and 85% of immediate postpartum LARC insertions—even though this group only comprises 45% of the delivering population. Overall, immediate postpartum contraception is uncommon (LARC, 13.5 per 10,000 deliveries; sterilization, 683 per 10,000 deliveries), but publicly insured women are overrepresented.⁵ This finding could reflect genuine differences in women's contraceptive preferences. It could also reflect differential peripartum counseling, unequal access to the full range of contraceptive methods, or more constrained decision-making among Medicaid beneficiaries who face insurance loss after the postpartum period.

Thus, race and social class have shaped—and in some cases restricted—women's reproductive healthcare options historically and in contemporary practice. This complicates current efforts to implement immediate postpartum LARC services in a way that meets all women's contraceptive preferences and needs.

IMMEDIATE POSTPARTUM LARC POLICY AND PRACTICE THAT PROMOTES REPRODUCTIVE JUSTICE

Equitable reproductive policies and practices would help unstratify the experience of reproduction and reproductive healthcare. What would that look like in the case of postpartum LARC? Policies that promote reproductive equity and autonomy would enable all women to: 1) access immediate postpartum LARC if desired, in programs that do not selectively target low-income women, women of color, or otherwise marginalized women; 2) decline LARC if they wish without judgment or pressure; and 3) access affordable LARC device removal at any point, independent of insurance status.

1) Promoting universal availability of immediate postpartum LARC

Reimbursement limits the availability of immediate postpartum LARC based on patients' source of payment and income. About half of state Medicaid agencies now provide coverage for inpatient LARC. Low-income women may also be eligible for private donor-sponsored programs that provide free LARC devices in academic hospitals. Coverage in commercial plans is not well-described, but is largely absent in at least some parts of the country.¹⁸

Current reimbursement policies have two main implications: first, lack of coverage prevents some women from getting immediate postpartum LARC when desired. Second, coverage of immediate postpartum LARC only via Medicaid or donor-sponsored programs with income eligibility preferentially targets lower income women for longer-acting contraception, and not more affluent women, stratifying care.

Clinicians can play an important role in advocating for universal payer coverage of immediate postpartum LARC services, via conversations with Medicaid and private insurers. However, payer reimbursement decisions will ultimately be largely outside the control of individual clinicians and hospitals, who must continue to care for patients as reimbursement policy evolves.

Against the current backdrop of uneven public and private insurance coverage, hospitals and clinicians must decide whether or not to offer immediate postpartum LARC. Currently, immediate postpartum LARC is provided almost exclusively at urban teaching hospitals, perhaps due to availability of clinical champions, financial and structural resources for implementation, and improved access to donor-funded LARC devices.⁵

If inpatient LARC services are established, hospitals must decide whether to offer it universally, as directed by patient preferences and clinical eligibility, or only to women with verified insurance coverage for this care. Offering this service only to women with Medicaid or only to low-income women eligible for donor-sponsored devices runs the risk of selectively promoting LARC to poor women. Even if well-intended to increase access, this further stratifies reproductive care. We believe that hospitals should strive to offer this service to all interested patients, with the disclosure that some may have out of pocket expenses.

For practical reasons, launching a complex new service with inconsistent reimbursement may not be feasible for many hospitals. Others may choose not to offer immediate postpartum LARC services due to religious-based policies. We believe that hospitals that do not offer immediate postpartum LARC should still discuss this treatment option with patients during prenatal care, so women have the option to transfer care if desired.

2) Protecting patient autonomy

Immediate postpartum LARC programs should strive to ensure that women provide truly informed consent and have free choice, including the ability to decline LARC without judgement or pressure. To safeguard against the possibility that provider biases might impact care recommendations, a hospital could implement standardized contraceptive counseling (e.g., with educational videos or counseling scripts) to ensure that all patients receive the same information. Hospitals should also refrain from setting benchmark performance targets based on LARC utilization, as this could fuel coercive practices and undermine patient-centered counseling.¹⁹

Ideally, contraceptive counseling would occur during routine prenatal care and include a discussion of: reproductive plans; the risks/benefits of immediate versus interval LARC insertion; contingency planning if immediate LARC insertion is contraindicated or unsuccessful; access to LARC removal; and information about the patient's right to change her mind. It may also be appropriate to offer immediate postpartum LARC placement to hospitalized women who have not received prenatal counseling. On one hand, potential for coercion is high if a woman is unable to fully engage in the consent process due to labor or medication. On the other hand, not offering a woman this option can limit her reproductive choices. Women are already expected to make many decisions about care (e.g., consent to emergent cesarean delivery) during hospitalization. While contraceptive counseling is ideally a process initiated during outpatient prenatal care, it can still be appropriately and ethically offered intrapartum, so long as the patient can engage in a robust informed consent process.

Last, insurance coverage may constrain contraception options, especially for women whose coverage ends after childbirth. While some women facing uninsurance choose sterilization in order to have long-term contraception, immediate postpartum LARC may enhance contraceptive autonomy by providing a reversible alternative. At the same time, clinicians ought to be careful to not portray LARC as the only reasonable option, when some women might prefer shorter-acting methods.

3) Ensuring LARC removal when desired

Equally important as free and informed contraceptive initiation is contraceptive discontinuation. All women will at some point require LARC removal due to desire to become pregnant, adverse device effects, device expiration, or preference. While immediate postpartum LARC provides an opportunity for women at risk of future insurance loss to initiate contraception during a period of coverage, the same group of women may later struggle to access device removal. Sites offering immediate postpartum LARC insertion need also to offer provisions for LARC removal at the time of a woman's choosing without out-of-pocket expenses. Such provisions might include offering a "no charge" visit for LARC removal to women without adequate insurance coverage.

IMPLICATIONS AND NEXT STEPS

There are significant potential benefits to immediate postpartum LARC insertion, yet implementing this care poses challenges for reproductive justice. Even well-intended policies and practices to increase contraceptive access can perpetuate reproductive inequities, and send messages (unintended or intended) that some people's childbearing is less valuable than others'. To ensure that programs to enhance LARC access do not further stratify reproduction, immediate postpartum LARC policies and services must be designed as part of a larger vision of reproductive justice. Service design should include strategic plans to promote universal availability, prevent coercion, and enable device removal. Such plans may be created through collaborative conversations with women's healthcare providers, health policy experts, ethicists, Medicaid and private payer administrators, reproductive justice advocates, and pregnant women. Such efforts must help ensure that *all* women can limit fertility or pursue pregnancy and parenthood according to their own wishes.

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