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Increasing Access to Intrauterine Devices and Contraceptive Implants

Committee on Health Care for Underserved Women and Contraceptive Equity Expert Work Group. This Committee Statement was developed by the ACOG Committee on Health Care for Underserved Women in collaboration with Sarah Horvath, MD, MSHP, FACOG, and Melissa Kottke, MD, MPH, MBA.

Everyone who desires long-acting reversible contraception should have timely access to contraceptive implants and intrauterine devices. Obstetrician–gynecologists and other reproductive health care clinicians can best serve those who want to delay or avoid pregnancy by adopting evidence-based practices and offering all medically appropriate contraceptive methods. Long-acting reversible contraceptive devices should be easily accessible to all people who want them, including adolescents and those who are nulliparous and after spontaneous or induced abortion and childbirth. To achieve equitable access, the American College of Obstetricians and Gynecologists supports the removal of financial barriers to contraception by advocating for coverage and appropriate payment and reimbursement for all contraceptive methods by all payers for all eligible patients.

SUMMARY OF RECOMMENDATIONS AND CONCLUSIONS

Based on the principles outlined in this Committee Statement, the American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations and conclusions:

Obstetrician–gynecologists (ob-gyns) and other reproductive health care clinicians should provide patient-centered counseling on all contraceptive options, including implants and intrauterine devices (IUDs); prioritize patient preferences and medical eligibility; and respect the patient's right to decline or postpone contraceptive care.

Obstetrician–gynecologists and other reproductive health care clinicians can improve access to long-acting reversible contraceptive (LARC) methods by adopting evidence-based practices, offering LARCs to all who are medically eligible, and facilitating the availability of same-day insertion of LARCs.

Clinicians should remove LARCs whenever requested by patients, for any reason, and

without regard to clinician concerns about cost or duration of use.

The American College of Obstetricians and Gynecologists supports the removal of financial barriers to contraception and advocates for insurance coverage and appropriate payment and reimbursement for all contraceptive methods by all payers for all eligible patients.

BACKGROUND

Long-acting reversible contraceptive methods, including IUDs and contraceptive implants, have few contraindications, and almost all patients are appropriate candidates for a LARC method.[1,2] This document includes updated recommendations to improve access to LARC methods. Clinical guidance regarding LARC methods is available elsewhere (see Practice Bulletin No. 186, *Long-Acting Reversible Contraception: Implants and Intrauterine Devices* at https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/11/long-acting-reversible-contraception-implants-and-intrauterine-devices; and US Medical Eligibility Criteria (US MEC) for Contraceptive Use, 2016 at https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html).

As of October 2022, there were six U.S. Food and Drug Administration–approved LARC devices in the United States: the etonogestrel contraceptive implant, the copper IUD, and four IUDs containing levonorgestrel. These methods provide high contraceptive efficacy, convenience, and method-specific noncontraceptive benefits. However, they also can have high upfront costs and require office visits with trained clinicians for both insertion and removal. When multiple methods of contraception are medically appropriate, patient preferences should always take precedence over any health care professional preferences, including health care professional–perceived advantages of particular methods in preventing unintended pregnancies among individuals with certain characteristics.

Long-acting reversible contraceptive methods have high patient satisfaction and continuation rates.[3] Unfortunately, multiple studies suggest that some patients who want LARC methods do not obtain them due to systemic and structural barriers.[4–6] In addition, contraceptive use and method choice vary across states, suggesting that inequities in access to methods may exist by geography.[7] Removing certain barriers by offering same-day insertion and eliminating cost sharing allows for individuals to access desired LARC methods at higher rates.[8–13] At the same time, programs and public health metrics that work to improve the availability of LARC should also prioritize improved access to all non-LARC contraceptive methods and should center patient method preference over uptake of particular types.[14–17]

RECOMMENDATIONS AND CONCLUSIONS

Obstetrician–gynecologists and other reproductive health care clinicians should provide patient-centered counseling on all contraceptive options, including implants and IUDs; prioritize patient preferences and medical eligibility; and respect the patient's right to decline or postpone contraceptive care.

Patient-centered counseling that prioritizes patient preferences and motivations promotes individual agency and autonomy in decision making. Risks, benefits, alternatives, potential cost, and access to LARC removal at a time of a patient's choosing should be discussed during the counseling process. In-depth guidance on contraceptive counseling can be found in ACOG's Committee Statement on *Patient-Centered Contraceptive Counseling* at https://www.acog.org/clinical/clinical-guidance/committee-statement/articles/2022/02/patient-centered-contraceptive-counseling, Committee Opinion 710, *Counseling Adolescents About Contraception* at https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/counseling-adolescents-about-contraception, and Committee Opinion 735, *Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices* at https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/adolescents-and-long-acting-reversible-contraception-implants-and-intrauterine-devices.

Multiple barriers impede access to IUDs after procedural abortion, surgical management of miscarriage, and childbirth, including clinician knowledge and skills gaps, inadequate insurance coverage, and challenges for payment and reimbursement.[18,19] Of note, patients may face difficulties with insurance coverage for a replacement device should expulsion occur, particularly when placed during the postpartum period.

Obstetrician–gynecologists and other reproductive health care clinicians can improve access to LARC methods by adopting evidence-based practices, offering LARCs to all medically eligible individuals, and facilitating the availability of same-day insertion of LARC.

Clinicians should work to overcome barriers to provision of all contraceptive methods, including those unique to LARC.[20] Although most ob-gyns offer IUDs in

their practices, just more than 50% offer the implant, with perceived lack of patient interest and clinician training gaps most frequently cited as barriers to provision.[21] In addition, although 82% of family physicians provide reproductive health care services, only about 22% regularly provide IUDs and just about 14% regularly provide implants.[22] Targeted reproductive health care training and support for family physicians and other clinicians, in addition to ob-gyns, can close gaps and improve access to all contraceptive methods.

The Office of Population Affairs developed contraceptive care performance measures endorsed by the National Quality Forum, including two measures designed to monitor access to LARC (Contraceptive Care Measures | HHS Office of Population Affairs). These population-level measures can be used to identify health care sites, regions, or populations with exceedingly low rates of LARC use (eg, less than 2%), which may indicate a lack of access to care. However, these measures should not be used at the individual level to set specific benchmarks for LARC uptake or to incentivize the use of particular methods, because this can encourage coercive behaviors. In the fall of 2020, the National Quality Forum endorsed a Patient Reported Outcome Performance Measure assessing the patient experience of contraceptive care. This measure can be used in tandem with contraceptive utilization measures to help ensure that efforts to enhance LARC access are equally focused on achieving a high-quality patient experience of care. Similarly, reproductive health, rights, and justice organizations have created guidelines that can be used by programs aiming to provide person-centered contraception (ReDefining Quality).

Obstetricians–gynecologists should facilitate same-day insertion of LARC methods to improve access to all contraceptive options. Many practices find it difficult to operationalize same-day insertion procedures, requiring multiple visits for IUDs and implant insertion.[8,9,23] Cost of stocking the devices, lack of insurance coverage or underinsurance, scheduling challenges, third-party pharmacy requirements, and non–evidence-based clinical protocols all serve as barriers to same-day IUD provision.[24] Programs that support "on-the-shelf" stocking and no-cost contraception for patients who are uninsured improve access to LARC methods.[25] Additionally, same-day IUD availability is essential for provision of the most effective form of emergency contraception.[26] Policies that allow an unused device prescribed for one patient to be used by another patient can facilitate same-day provision and reduce waste. The ability to prestock LARC devices and bill insurance at the time of insertion can also facilitate same-day provision.

A team approach to increasing patient access and decreasing length and number of office visits needed for device insertion may include training advanced practice clinicians on device insertion, training nonphysician team members to provide contraceptive counseling, and implementing preappointment insurance verification of coverage to facilitate efficient, same-day insertion of LARCs. Importantly, routine screening for sexually transmitted infections is not required before insertion of a LARC device, and insertion of these devices does not need to be delayed for patients awaiting test results (Long-Acting Reversible Contraception: Implants and Intrauterine Devices | ACOG).[27]

In addition, ob-gyns should offer all medically appropriate contraceptive methods to all patients. Although clinicians generally have favorable attitudes toward IUDs, they may use overly restrictive criteria to identify IUD candidates, such as exclusion of adolescent or nulliparous patients.[28] A recent survey showed that 92% of clinicians providing IUDs did offer them to patients younger than age 21 years, but clinician biases, institutional policies, and state legislation may still inappropriately limit provision to minors.[23,29] Completion of continuing medical education–accredited LARC training showed sustained improvements in clinician knowledge, attitudes, and patient counseling for LARC methods.[30] Clinical protocols should be updated routinely based on ACOG-endorsed Centers for Disease Control and Prevention Medical Eligibility Criteria and Selected Practice Recommendations for Contraceptive Use.[1,31]

Some clinicians hesitate to provide LARC devices to patients desiring contraception for a shorter time period than the devices' U.S. Food and Drug Administration–approved duration of use.[32] Despite the potential for high upfront costs, the implant and IUDs are highly cost effective compared with other contraceptive methods, even with relatively short-term (12–24 months) use.[33,34] A patient-centered approach also dictates that clinicians remove LARC whenever requested by patients for any reason and without regard to clinician concerns about cost or duration of use.

Additionally, on initiation of LARC use, patients should be counseled that removal of LARC devices requires access to a trained clinician, which can be expensive for patients who are uninsured or underinsured. Discussion of future access to clinicians, including safety net health care professionals, and the associated cost of removal should be a part of the informed consent process before placement. Although subpar reimbursement can be challenging, clinicians who perform LARC insertion should strive to provide low-cost or no-cost removal for patients who cannot otherwise access this care. Patients may be unable to access insertion or removal or both for many reasons, including but not limited to financial concerns, such as loss of insurance coverage; residing in rural areas or abroad where there may be limited access to trained health care professionals; fear of accessing care due to immigration status; and lack of routine access to gynecologic care.

Clinicians should remove LARC whenever requested by patients, for any reason, and without regard to clinician concerns about cost or duration of use.

To minimize ongoing systemic oppression, contraceptive counselors should be cognizant of the United States' significant history of coercive contraceptive and sterilization practices, disproportionately affecting people of color, people with disabilities, people experiencing socioeconomic marginalization, people involved in the legal or carceral systems, and people in immigrant communities.[2,35–38] U.S. reproductive health innovations often have been accompanied by deeply problematic exploitation, from the eugenics movement of the early 20th century and coerced sterilization of Puerto Rican women under Law 116, to the Indian Health Services' forced sterilization of Native American women in the 1960s and 1970s, to the history of the "Mississippi appendectomy"—the involuntary sterilization of Black women in the South. U.[39] In addition to deceptive and forced sterilizations, contraceptive coercion practices that focus on those with low incomes and people of color are not only historical but continue to the present day. Oral contraceptive experimentation without consent on Puerto Rican women in the 1950s, mandates making receipt of public assistance contingent on the use of contraceptive implants or injections beginning in the 1990s, and contraceptive initiatives directed toward certain marginalized communities, ongoing even today, are all examples of reproductive injustices in this country.

Directive counseling by health care practitioners that lacks a patient-centered, shared decision-making approach is coercive and negatively affects patient experience and satisfaction. In one qualitative study of patient experiences with contraceptive counseling at the time of abortion, almost half of study participants perceived coercion from their clinicians related to pressure to use a LARC method or immediately initiate a method or both. Participants who were offered a range of contraceptive options and time for deliberation described greater autonomy and satisfaction.[39] Another study indicated that patients, particularly people of color, felt that their preferences regarding contraceptive selection or removal were not honored due to health care practitioner biases and systemic racism.[40] Health care professionals should provide all patients with comprehensive, scientifically accurate information about the full range of available contraceptive options.[41] The decision to initiate, continue or discontinue any contraceptive method belongs to the patient and should be honored.

The American College of Obstetricians and Gynecologists supports the removal of financial barriers to contraception and advocates for insurance coverage and appropriate payment and reimbursement for all contraceptive methods by all payers for all eligible patients.

Insurance type and benefit design affect access to contraceptive care. Medicaid payment and reimbursement rates and structures vary significantly both among and within states. Medicaid managed care organizations; emergency Medicaid; religious, moral, and other exemptions in employer-sponsored plans; and plan utilization rules may lead to gaps in contraceptive coverage.[42] Inequities by insurance type exist; compared with patients with private insurance, patients with Medicaid insurance are less likely to receive LARC when two or more visits are required (79% vs 66%).[42] Additionally, some reproductive-aged patients with disabilities and comorbidities that can increase pregnancy-associated risks are covered by Medicare, which typically does not provide contraceptive coverage. The high cost of LARC devices can present a barrier when ob-gyns receive reimbursement from payers that is below the cost of the device and insertion procedure. Louisiana showed a twofold increase in LARC use when Medicaid policy increased the contraceptive device reimbursement rate to the wholesale acquisition cost.[43] Access to immediate postpartum LARC has been hampered by inadequate reimbursement for devices and insertion procedures separate from the global delivery fee.[42]

Insurance regulations and broader health policy may also limit access to contraceptive care. Some state Medicaid programs, for example, place limits on the types of practitioners who can serve patients who have Medicaid insurance. Any restriction of qualified health care professionals reduces access to care. Payment and reimbursement policies that restrict abortion coverage or provision of multiple services during the same visit complicate billing procedures for covered contraceptive services and serve as a barrier to access at the time of abortion care, the annual preventive care visit, or postpartum care.[44]

Obstetrician–gynecologists and other reproductive health care clinicians are encouraged to become familiar with and support local, state, federal, and private programs that improve affordability and availability of the full range of contraceptive methods. Since implementation of the Affordable Care Act, most insurance plans cover all contraceptives, including LARC methods, with no patient cost sharing. However, this requirement has been challenged in the courts by government agencies and religious and secular employers, with attempts to roll back coverage for individual patients.[45,46] Many practices receiving federal Title X family planning funding, Planned Parenthood clinics, and federally qualified health centers offer LARC methods at low or no cost. However, some people remain uninsured or otherwise unable to access these safety net health care professionals.[47]

CONCLUSION

Obstetrician–gynecologists and other reproductive health care clinicians play a critical role in improving access to LARC methods. All reproductive health care clinicians can adopt best practices for providing equitable, patient-centered contraceptive care, including patient-centered counseling, same-day LARC insertion, and LARC removal on patient request. The American College of Obstetricians and Gynecologists supports policies at the institutional, local, state, and federal levels that improve access to all contraceptive methods, including LARCs.

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CONFLICT OF INTEREST STATEMENT

All ACOG committee members and authors have submitted a conflict of interest disclosure statement related to this published product. Any potential conflicts have been considered and managed in accordance with ACOG's Conflict of Interest Disclosure Policy. The ACOG

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