Why was this study conducted?

Nearly half of all pregnancies in the United States (45%) are unintended, and unintended pregnancies are associated with adverse infant and maternal outcomes. Long-acting reversible contraceptives (LARCs) are the most effective reversible contraceptive method at reducing unintended pregnancy rates, yet only 14% of contraceptive users in the US use LARCs. LARC use may be lower than other methods due to inequitable access to LARCs. One barrier to LARC access is providers’ ability to provide LARCs, such as lacking the training necessary to insert LARCs or inadequate reimbursement.

What was the purpose of this study?

The purpose of this study was to examine if a Louisiana Medicaid policy change in 2014 that increased the reimbursement rate for LARCs changed LARC uptake among women at risk of unintended pregnancy.

How was this study conducted?

This study was conducted using Medicaid claims data from 2013 (one year before the policy change) to 2015 (one year after) to measure patterns of LARC uptake among women at risk of unintended pregnancy that were using contraception. Patients at risk are defined as women between the ages of 15 and 44 who are able to get pregnant but were not pregnant at the time of the study. The following patient and provider characteristics available in Medicaid claims data were examined to determine if they impacted LARC uptake: patient race, age, residence in rural or urban parish, postpartum status, provider location in an urban or rural parish, and provider specialty.
What are the main results?
After the increase in Medicaid reimbursement, there was a two-fold increase in the LARC use in 2015. LARC use was also more likely across all patient and provider characteristics after the policy change.

What do these findings mean?
These findings reveal that reducing a financial barrier for providers increased the likelihood of LARC provision and uptake. This means that strategies to improve equitable access to all contraceptives should consider adequate LARC reimbursement for healthcare providers.

What are the strengths and limitations of the study?
A strength of this study is the use of claims data because it provides an objective measure of the use and provision of LARCs over time. A limitation of the study is that we were unable to account for factors that influence LARC uptake not included in claims, such as LARC insertion trainings or contraceptive counseling practices.

How can these results be used to improve the health of women and their families?
Alongside encouragement of patient-centered comprehensive counseling, efforts to improve equitable access for women seeking family planning services should consider removing provider-level barriers, such as low reimbursement rates.