

# Editorials

## Immediate Postpartum LARC: An Underused Contraceptive Option

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In the United States, use of long-acting reversible contraceptives (LARC) such as intrauterine devices (IUDs) and implants doubled between 2006 and 2012 to nearly 12% of women 15 to 44 years of age who were using contraception.<sup>1</sup> However, opportunities exist to expand access to and use of these highly effective contraceptives. Provision of LARC in the immediate postpartum period may aid women in birth spacing and help avoid short interpregnancy intervals (i.e., less than six to 18 months), which are associated with adverse obstetric and neonatal outcomes, including preterm birth, low birth weight, and infants being small for gestational age.<sup>2</sup>

Offering immediate postpartum insertion of LARC is supported by the Centers for Disease Control and Prevention,<sup>3</sup> the American College of Obstetricians and Gynecologists,<sup>4</sup> the American Academy of Family Physicians,<sup>5</sup> the American Academy of Pediatrics,<sup>6</sup> and the Centers for Medicare and Medicaid Services.<sup>7</sup> The provision of immediate postpartum LARC is safe for most women, including those who are breastfeeding, according to the Centers for Disease Control and Prevention.<sup>8</sup> Although implants can be placed before discharge from the hospital, IUDs may be inserted within 10 minutes of placental delivery or intraoperatively prior to uterine closure after cesarean delivery.

A 2015 Cochrane review summarized the benefits of immediate postpartum IUD insertion based on data from four eligible randomized controlled trials that included 243 women.<sup>9</sup> Women desiring an IUD who were randomized to immediate insertion were twice as likely to be using an IUD for contraception six months after delivery (odds ratio [OR] = 2.04; 95% confidence interval [CI], 1.10 to 4.09) compared with those who waited for routine six-week postpartum placement. Although women appeared to be more likely to receive an IUD in the immediate-placement group compared with those waiting six weeks, this estimate was imprecise (OR = 4.07; 95% CI, 0.54 to 30.40). Repeat pregnancies

were rare, and the included studies did not evaluate pregnancy incidence with alternative contraceptive regimens compared with IUDs. Previous research demonstrates that LARC is superior to common shorter-acting contraceptive methods (e.g., pills, patches, rings) for pregnancy prevention.<sup>10</sup>

Women undergoing immediate insertion experienced a greater risk of IUD expulsion compared with those who had delayed insertion (19 out of 113 [17%] and three out of 97 [3%], respectively; OR = 4.89; 95% CI, 1.47 to 16.32), with the majority of women opting to have the device replaced. Harms (e.g., urogenital infections) were rare and similar in each group. Despite the increased expulsion rate, immediate postpartum IUD insertion is cost-saving until expulsion rates exceed 38%, and cost-effective (at a willingness-to-pay threshold of \$50,000) up to expulsion rates of 56%.<sup>11</sup> These threshold expulsion rates are more than two to three times what was observed in the Cochrane review.

Postpartum follow-up rates observed in the individual randomized controlled trials were also far greater than in the real world. The studies report that 80% to 98% of women attended follow-up visits, although in actual practice in the United States, only 76% of commercially insured women and 62% of publicly insured women attend a postpartum visit.<sup>12</sup> These different follow-up rates may underestimate the gains in pregnancy prevention with immediate postpartum LARC in real-world settings.

In April 2016, the Centers for Medicare and Medicaid Services encouraged state Medicaid programs to increase access to LARC and provide coverage for immediate postpartum LARC.<sup>7</sup> However, as of December 2016, only 24 states offered coverage in the immediate postpartum period despite all Medicaid agencies covering LARC in the outpatient setting.<sup>13</sup> The main barrier to offering immediate postpartum LARC involves lack of reimbursement for device and insertion costs that exceed the global delivery fee. Many state Medicaid programs and commercial insurers have developed their own reimbursement procedures, allowing hospitals and physicians to bill outside of the global delivery fee.<sup>14</sup>

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Providing immediate postpartum LARC to women who want it is an evidence-based, patient-centered, and safe practice. It may also allow for increased efficiency at the postpartum visit by providing more time to address future pregnancy planning, reflect on changes to the mother's health or risks based on conditions identified during the recent pregnancy, screen for postpartum anxiety or depression, monitor breastfeeding, and assist women who are transitioning back to work. Greater evidence on training, best practices, and use is needed, presenting opportunities for future research.

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