

PREVENTING ADOLESCENT PREGNANCY IN PENNSYLVANIA THROUGH LONG-ACTING REVERSIBLE CONTRACEPTIVES

THE PUBLIC HEALTH PROBLEM

Unintended pregnancy and abortion rates are higher in the United States than in most other developed countries. The problem of unintended pregnancy disproportionately affects adolescent women. Almost half (49%) of all pregnancies in the United States, and 80-90% among adolescent and young women ages 15 to 24, are unintended.¹ The direct cause of teen pregnancies, the majority of which are to young women 17 or older, is the lack of consistent and correct use of effective contraception.² Unintended pregnancy can have a negative impact not only on the lives of the teens and young women, but also on their parents and their children. Moreover, the public costs of teen childbearing, which reached \$9.4 billion in 2010, are a significant cause for concern.³

Pennsylvania's teen birth rate in 2013 was 21 births per 1,000 females.⁴ In total, nearly 8,700 Pennsylvania teens gave birth in 2013. While this was lower than rates in about two-thirds of U.S. states, it was only marginally better than the national average of 26 births per 1,000 females.⁴

Compared to the national average, Pennsylvania teens experience greater disparity in birth rates based on race and ethnicity. In Pennsylvania, the teen birth rates for young African American women (47 per 1,000) and young Hispanic women (51 per 1,000) are more than three times higher than the birth rate for their white counterparts (14 per 1,000). The national teen birth rate also demonstrates racial and ethnic disparities, but to a lesser extent, with about two times the rate of teen births for African American and Hispanic young women than for their white counterparts (39, 42, and 18 per 1,000, respectively).⁴ Additionally, teen birth rates in Pennsylvania vary greatly by region. In 2012, the most recent year for which data is available, the City of Philadelphia had the highest teen birth rate of 47 per 1,000.⁵ These rates were much higher than the the Commonwealth's 2012 birth rate of 24 per 1,000.⁴

Teen childbearing cost Pennsylvania taxpayers an estimated \$409 million in 2010, the most recent year for which data is available.³

THE EVIDENCE: BENEFITS OF LONG-ACTING REVERSIBLE CONTRACEPTIVES

Although almost all sexually active adolescents report using some method of contraception, the most effective methods are rarely selected. Instead, adolescents most commonly use methods like withdrawal, condoms, oral contraceptive pills, contraceptive patch, the vaginal ring, and hormone injections, all of which have a relatively high discontinuation rate and failure rate when used inconsistently and incorrectly.^{6,7,8} Therefore, even adolescents who are acting to prevent pregnancy may find themselves pregnant due to the failure of their chosen birth control method. Long-acting reversible contraception (LARC) methods are up to twenty times more effective than oral contraceptive pills, according to research from 2012 involving more than 7,000 women.⁹

LARC methods are small devices which are placed inside a woman's uterus (or womb) or under the skin

on the inner arm. LARCs placed inside the uterus prevent pregnancy mainly by preventing fertilization of the egg by sperm, and those placed under the skin of the arm do so by stopping ovulation. These devices work over three to ten years to provide excellent birth control, and the evidence demonstrates that LARC methods are safe.¹⁰

Research published in 2014 has demonstrated the potential large-scale effect of increased access to LARCs on adolescent pregnancy, birth and abortion rates. In two separate studies conducted in St. Louis, MO^{11,12} and Colorado,¹³ adolescents who were provided access to comprehensive contraceptive counseling and low or no-cost insertion services had high rates of LARC uptake and continuation. The resulting declines in teen pregnancy, birth and abortion rates outpaced the projected declines based on national trends.



THE CHALLENGE: KEY INSTITUTIONAL AND FINANCIAL BARRIERS TO ACCESSING LARCS

Adolescents and the clinicians who treat them face a number of barriers to LARC methods. Many providers who routinely care for adolescents feel they lack sufficient knowledge about LARC methods to counsel adolescents. Moreover, many clinicians who provide LARC services feel inadequately trained to provide developmentally-appropriate contraceptive counseling services specifically to adolescent women. The St. Louis and Colorado initiatives demonstrated how improving access to high quality counseling and clinical services from experienced providers can address patient and provider concerns about LARC usage and safety.

Payers are also critical to the success of LARC methods to prevent adolescent pregnancy. Though

the upfront costs for LARCs are higher than other contraceptive methods, the return on investment in preventing unwanted pregnancies mitigates the price of investment. The state of Colorado saved \$42.5 million in health expenditures associated with teen birth as a result of its LARC initiative.¹⁴ Nationally, public funding for contraception in 2010 resulted in over \$10.5 billion in savings by reducing the number of unintended pregnancies and the resulting pregnancy-related care and infant care.¹⁵ The Brookings Institution found that public investment in family planning programs would be even more effective if LARC usage was increased.¹⁶

To address the public health problem of adolescent pregnancy in Pennsylvania, we recommend the following:

1 Expand education for clinicians and adolescents

about the safety and efficacy of LARCs: Medical and nursing schools, residency programs, professional organizations and device manufacturers should help to expand access to LARC methods by providing training opportunities, including Continuing Medical Education (CME)/Continuing Education Unit (CEU) credits for health care providers on counseling about and administering LARC devices for adolescents. To solidify the importance of LARC services, questions about LARCs should be added to licensing exams for health professionals. Clinic staff should also be trained to create LARC-friendly health care environments that consider every step of the process from the clinic appointment schedulers to the front desk staff, medical coders, billing and financial management teams.

2 Clarify the scope of reimbursement of LARC methods in the Pennsylvania Medicaid Program:

Given some uncertainty about the reimbursement process for LARC methods, the Pennsylvania Medicaid program should reaffirm that PA Medicaid covers all forms of LARC methods, and does not require prior authorizations or co-payments. In addition, the Pennsylvania Department of Human Services (DHS) should join 18 other states

that have increased access to LARCs, including postpartum LARCs.¹⁷ Through PA Medicaid and Managed Care Organizations (MCOs), DHS can increase access to LARC methods through improved reimbursement methods including for LARC devices and insertion costs in outpatient settings, as well as for inpatient settings by separating the payment for LARCs from bundled inpatient or delivery fees. Additionally, DHS can adopt innovative approaches to support the upfront financial costs of supplying LARC devices in outpatient settings, and combine reimbursements for same-day provider counseling and insertion.

3 All hospitals that care for reproductive-age women, whether adult or pediatric, should negotiate for broad coverage of LARC services in their contracts with private and public payers:

This recommendation may be unnecessary if the PA Medicaid program acts pursuant to the above recommendation. However, in the interim, providers should ensure that their Medicaid MCO contracts allow access to LARC services without barriers, such as the requirement for prior authorization, thereby allowing same day provision of LARC services. Because LARC services can be delivered by a broad range of clinicians, coverage should not be restricted based on a provider's credentials (e.g., physician versus nurse practitioner) or medical specialty (e.g., OB/GYN versus family physician).

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The aim of PolicyLab at The Children's Hospital of Philadelphia is to achieve optimal child health and well-being by informing program and policy changes through interdisciplinary research.

PolicyLab develops evidence-based solutions for the most challenging health-related issues affecting children. We partner with numerous stakeholders in traditional healthcare and other community locations to identify the programs, practices, and policies that support the best outcomes for children and their families. PolicyLab disseminates its findings beyond research and academic communities as part of its commitment to transform evidence to action.