GYNECOLOGY

Funding policies and postabortion long-acting reversible contraception: results from a cluster randomized trial

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BACKGROUND: Almost one-half of women having an abortion in the United States have had a previous procedure, which highlights a failure to provide adequate preventive care. Provision of intrauterine devices and implants, which have high upfront costs, can be uniquely challenging in the abortion care setting.

OBJECTIVE: We conducted a study of a clinic-wide training intervention on long-acting reversible contraception and examined the effect of the intervention, insurance coverage, and funding policies on the use of long-acting contraceptives after an abortion.

STUDY DESIGN: This subanalysis of a cluster, randomized trial examines data from the 648 patients who had undergone an abortion who were recruited from 17 reproductive health centers across the United States. The trial followed participants 18-25 years old who did not desire pregnancy for a year. We measured the effect of the intervention, health insurance, and funding policies on contraceptive outcomes, which included intrauterine device and implant counseling and selection at the abortion visit, with the use of logistic regression with generalized estimating equations for clustering. We used survival analysis to model the actual initiation of these methods over 1 year.

RESULTS: Women who obtained abortion care at intervention sites were more likely to report intrauterine device and implant counseling (70% vs 41%; adjusted odds ratio, 3.83; 95% confidence interval, 2.37—6.19) and the selection of these methods (36% vs 21%; adjusted odds ratio, 2.11; 95% confidence interval, 1.39—3.21). However, the actual initiation of methods was similar between study arms (22/100 woman-years each; adjusted hazard ratio, 0.88; 95% confidence interval, 0.51—1.51). Health insurance and funding policies were important for the initiation of intrauterine devices and implants. Compared with uninsured women, those women with public health insurance had a far higher initiation rate (adjusted hazard ratio, 2.18; 95% confidence interval, 1.31—3.62). Women at sites that provide state Medicaid enrollees abortion coverage also had a higher initiation rate (adjusted hazard ratio, 1.73; 95% confidence interval, 1.04—2.88), as did those at sites with state mandates for private health insurance to cover contraception (adjusted hazard ratio, 1.80; 95% confidence interval, 1.06—3.07). Few of the women with private insurance used it to pay for the abortion (28%), but those who did initiated long-acting contraceptive methods at almost twice the rate as women who paid for it themselves or with donated funds (adjusted hazard ratio, 1.94; 95% confidence interval, 1.10—3.43).

CONCLUSIONS: The clinic-wide training increased long-acting reversible contraceptive counseling and selection but did not change initiation for abortion patients. Long-acting method use after abortion was associated strongly with funding. Restrictions on the coverage of abortion and contraceptives in abortion settings prevent the initiation of desired long-acting methods.

Key words: abortion, insurance, long-acting reversible contraceptive, policy, postabortion contraception

Almost one-half of the women in the United States who have an abortion have had a previous procedure, which highlights a failure to provide adequate preventive care.[1] As is the case for all women wanting to prevent pregnancy, abortion patients stand to benefit from receiving information and access to a range of Food and Drug Administration—approved contraceptives that include long-acting reversible contraceptives (LARCs). Intrauterine devices (IUDs) and the subdermal implant are the most effective reversible contraceptives[2] and are safe to initiate on the day of an aspiration abortion.[3,4] LARC use is low in the United States compared with other developed countries,[5] at approximately 7% of reproductive-aged women,[6] which may contribute to the high unintended pregnancy rate.[7]

Providing LARC methods in the abortion care setting has particular challenges. Although very cost-effective over time,[8,9] LARC methods have high upfront costs. They can be unaffordable for women without health insurance or when devices or insertion fees are not fully covered.[10,11] There are also financial barriers to offering contraception during an abortion visit in some settings, including strict regulations regarding Title X funding or prohibitions against the use of state family planning funds.[12,13] Some abortion facilities face difficulties billing insurance for contraceptive services, given poorly defined coverage or need for preauthorization.[14] Others face obstacles with LARC counseling, stocking, and placement because of resource shortages.[12]

Although approximately two-thirds of US obstetrician-gynecologists agree that IUDs can be placed immediately after abortion, only 27% of those who offer abortions provide postabortion IUDs.[15] For LARC methods to be offered after the abortion, provider knowledge about the methods and patient eligibility, as well as clinical training, are required.[14] Lack of training can contribute to lower provision,[15,16] as can patient misconceptions about IUD and implant safety and use after the abortion.[17,18]

This analysis examines postabortion contraceptive care with data from a large

Cite this article as: Rocca CH, Thompson KMJ, Goodman S, et al. Funding policies and postabortion long-acting reversible contraception: results from a cluster randomized trial. Am J Obstet Gynecol 2016;214:716.e1-8.

0002-9378/$36.00

http://dx.doi.org/10.1016/j.ajog.2015.12.009

cluster randomized trial with Planned Parenthood health centers across the United States. The trial evaluated the impact of a clinic-wide provider training about IUDs and implants on women's access to the methods and unintended pregnancy.[19] Primary analyses indicated that the intervention reduced pregnancy rates among women in family planning care by almost one-half; however, in the abortion care setting, high pregnancy rates persisted over the next year.[19] This subanalysis assesses the role of health insurance and funding policies in access to postabortion LARC. Understanding coverage factors that impede contraceptive uptake can help identify policy changes and the interventions that are needed to support women's reproductive health.

Materials and Methods

Study design and procedures

We conducted a cluster randomized trial of 40 Planned Parenthood health centers that served diverse, low-income women. Study details are described elsewhere.[19] Briefly, eligible clinics had ≤20% LARC use, a patient volume of ≥400 annually, no ongoing LARC interventions or special funding programs, and no shared staff with other study clinics. The study randomly allocated clinics to receive LARC training (intervention, 20 clinics) or provide standard of care (control, 20 clinics) and concealed allocation until study initiation. Of the 40 participating sites, 23 sites recruited clients who were seeking general reproductive health services; the other 17 sites recruited women who were having abortions. This subanalysis uses data from the participants at the 17 sites located in a range of states (CA, CO, CT, FL, ID, MN, NC, OH, PA, WA) that provided abortion care.

Staff members at intervention clinics participated in a continuing medical education–accredited training session. The training emphasized updated LARC evidence, eligibility, counseling, and provision skills, which included same-day insertion when possible.[3] The training included patient-centered counseling skills such as open-ended questions, reproductive life planning, ethical issues specific to LARC that included removal when desired, and incorporation of the World Health Organization tiered contraceptive effectiveness chart.[20,21] Clinicians received hands-on IUD training with models, and we facilitated implant trainings with the manufacturer. All sites maintained usual costs for contraceptives.

After the training at intervention sites, we recruited a cohort of women from all study clinics between May 2011 and March 2012 and followed participants for 1 year. Eligible women were 18-25 years old, sexually active, not desiring pregnancy within a year, and were receiving contraceptive counseling. Women at the 17 abortion care sites were eligible to enroll on the day of an aspiration abortion or when mifepristone medication abortion was initiated. After providing informed consent and completing the enrollment visit, participants filled out a self-administered questionnaire that covered sociodemographics, pregnancy attitudes, contraceptive history, and methods discussed and selected at the visit. Providers completed a visit summary that documented abortion type, gestational age, and sources of payment for abortion.

Participants who underwent phone or online follow-up questionnaires quarterly for 1 year received $20 remuneration for each questionnaire. Investigators conducted medical record reviews at the end of 1 year. Clinic managers at each site completed surveys at baseline and study completion regarding clinic abortion and contraceptive care practices. The University of California, San Francisco, Committee on Human Research and the Allendale Investigational Review Board approved the study.

Measures

Outcomes

We assessed 3 outcomes to capture a woman's access to LARC. To measure LARC counseling, we used a question on the baseline participant survey about whether a counselor, nurse, or doctor had discussed the IUD or implant during the abortion visit. We asked participants which method of birth control they decided to use at the visit or in the last week, if any, and created a dichotomous variable for selecting whether to use a LARC method. Finally, we assessed the actual initiation of a LARC method over 1 year using follow-up surveys and medical records to document IUD and implant insertions. We also used 5 questions about LARC effectiveness and traits to create a knowledge scale (range, 0-5, $\alpha = .68$).

Patient funding

Participants reported their health insurance type (public [Medicaid, other state program], private, no insurance, don't know). The visit summary indicated payment sources for the abortion (state Medicaid, private insurance, self or donated funds).

Funding policies

Guttmacher Institute data were used to indicate whether the clinic was in a state with the following policies: state Medicaid covers abortion care; abortion facilities can receive state family planning funds; Medicaid family planning expansion program exists; and private health insurance is mandated to cover contraceptives.[13] Policy data aligned with dates of participant contact. We also examined data from the clinic manager survey on whether the site provided immediate postaspiration abortion LARC. Finally, to address the possibility that policy associations with LARC outcomes were not merely due to social climate around contraception and abortion at the site, we assessed 2 funding variables that we hypothesized would not be associated with LARC use. We included a measure of whether the site provided reduced-cost contraceptive care through the Title X family planning program, which is regulated strictly in the abortion setting, from the manager survey. We used Guttmacher Institute data to indicate whether the site was in a state with a mandated waiting period before abortion.[13]

Clinic intervention and control variables

All analytic models included the study arm (intervention, control). The following control variables were selected a priori as being associated with LARC