

INCREASING ACCESS TO LONG-ACTING REVERSIBLE CONTRACEPTION & PROTECTING PATIENT AUTONOMY

A RESOURCE FOR EVALUATING LARC
PUBLIC POLICY INITIATIVES

A project of the National Institute for Reproductive Health & the National Women's Health Network



How to Use This Document

This resource is intended to support reproductive health, rights, and justice advocates calling for or responding to proposed legislation or policy initiatives related to long-acting reversible contraception (LARC), a category of contraception that includes intrauterine devices (IUDs) and implants. Advocates can use this document to inform their thinking about the impact of a proposed or existing policy and as a basis for feedback to policymakers and other stakeholders. This document is both informed by, and intended to be used in conjunction with, the “LARC Statement of Principles” developed by SisterSong and the National Women’s Health Network (NWHN).¹ Because this document focuses on how to analyze existing or pending legislation, it does not go into depth on writing bills, navigating the regulatory and implementation processes that are vital to increasing access to LARC, or achieving systems-level change within institutions seeking to provide LARC. The National Institute for Reproductive Health (NIRH) and the NWHN are available to assist advocates in exploring those more involved issues in greater depth and developing a tailored approach to address them.

1. Available online at tinyurl.com/LARCprinciples

Introduction

SINCE THE EARLY 2000S, there has been growing interest among advocates, policymakers, and health care providers in the benefits of LARC and the barriers people face in accessing it.² These methods are highly effective at preventing pregnancy, last for an extended period of time, and once inserted, work without user action. Unlike some other birth control methods, they are designed to be inserted and removed by a clinician, not the user.

Many people desire long-acting, highly effective contraception; increasing access to LARC is a positive response to patient preferences. Making LARC widely available requires training clinicians, changing service delivery to reduce medically unnecessary hurdles, and addressing the high cost of devices for both users and clinicians — challenges which are often best addressed through public policy. The contraceptive coverage requirement of the Patient Protection and Affordable Care Act (ACA), for example, was a key step in making LARC methods affordable for most insured women, and their use of these methods subsequently increased.³ Yet cost remains a significant barrier to access for many people, in part because of the cost burden on providers who would like to stock LARC devices but cannot afford to do so. A 2015 survey found that four in 10 clinics did not keep a supply of devices on hand due to the high cost of most LARC devices.⁴

It is imperative, however, that policies to increase LARC access include safeguards to protect against reproductive coercion, because LARC necessarily places some measure of control with the provider rather than the patient. New proposals should be evaluated in the context of the long history of state-sanctioned efforts to control the fertility of certain groups and must be carefully designed to ensure that the rights of all people to control their fertility are protected and respected.

State-sanctioned reproductive coercion is not a relic of the distant past. Reproductive coercion targeting incarcerated individuals, people with disabilities, low-income people, and communities of color has been documented well into the 21st century⁵ and actively shapes how communities who have been marginalized and/or made vulnerable interact with public health initiatives today. In 2018, for

2. Contraceptive method use in the United States: trends and characteristics between 2008, 2012 and 2014. Megan L. Kavanaugh & Jenna Jerman. *Contraception*, Volume 97, Issue 1, January 2018, Pages 14-21.

3. The Impact of the Affordable Care Act on Contraceptive Use and Costs among Privately Insured Women. Ashley H. Snyder, et al. *Women's Health Issues*, May–June, 2018, Volume 28, Issue 3, Pages 219–223.

4. Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols. Mia R. Zoln & Jennifer J. Frost. Guttmacher Institute Report, November 2016. <https://www.guttmacher.org/report/publicly-funded-family-planning-clinic-survey-2015>. Accessed 9/9/18.

5. Recent examples of reproductive coercion can be found at <https://nwhn.org/LARCs/>

example, Tennessee lawmakers crafted and passed anti-coercion legislation⁶ after a judge in White County was found to be offering a reduced jail sentence to people who chose to have a LARC device inserted.⁷ Doctors in the California prison system were caught illegally coercing women who were incarcerated into sterilization against their will as recently as 2010. Involuntary sterilization was authorized by state law in 33 states for much of the 20th century, and many of the survivors of forced sterilization are still alive today.^{8, 9}

Food and Drug Administration (FDA) approval of the first contraceptive implant, Norplant, in 1990, led to the introduction of a flurry of coercive state bills that, if enacted, would have tied LARC use to welfare benefits and access to publicly funded abortion.¹⁰ States including California and South Dakota implemented a range of coercive policies in the 1990s and 2000s designed to link LARC use to government-imposed limits on the ability of low-income people to control their own fertility. Government funding was used to provide Norplant in school-based and other clinics, but clinic personnel were not trained on how to remove the device. These “insertion-only” services left low-income people, particularly people of color and teens, stuck with devices in their bodies that they no longer wanted and were unable to remove. As advocates in states across the country press for, or respond to, legislation intended to regulate or expand access to LARC, this document offers guidance on how to analyze, understand, and ultimately take a position on relevant policies.

Trends in LARC Bills

PROACTIVE EFFORTS by policymakers and stakeholders have led to an increase in the introduction and enactment of state-level legislation and regulation related to LARC access and funding. Three of the most common LARC-related policies are:

- **Funding for LARC in community clinics or within departments of health:** These programs allocate funding for LARC devices and/or provision of care in specific settings and are meant to address the problem of high costs of LARC

6. Senate Bill 2133 (2018). Tennessee General Assembly.

7. “Judge to inmates: Get sterilized and I’ll shave off jail time.” Derek Hawkins, Washington Post, July 21, 2017. https://www.washingtonpost.com/news/morning-mix/wp/2017/07/21/judge-to-inmates-get-sterilized-and-ill-shave-off-jail-time/?utm_term=.ef27dd87ccdf. Accessed 4/8/18.

8. Eugenic Sterilization Laws. Paul Lombardo, University of Virginia, undated. <http://www.eugenicsarchive.org/html/eugenics/essay8text.html>. Accessed 9/9/18.

9. “Let’s compensate victims of California’s forced sterilization program — quickly, before they die.” Los Angeles Times Editorial Board, Los Angeles Times, May 18, 2018. <http://www.latimes.com/opinion/editorials/la-ed-senate-bill-eugenics-compensation-20180518-story.html>. Accessed 9/9/18.

10. Guarding Against Coercion While Ensuring Access: A Delicate Balance. Rachel Benson Gold, Guttmacher Institute, September 2014. Guttmacher Policy Review, volume 17, issue 3.

devices for providers. For example, in 2018, **New Mexico** included funding in their budget, **HB 2**, for LARC devices and provider training.¹¹

- **LARC pilot programs:** From 2009 - 2015, a privately funded initiative in Colorado expanded LARC access by funding provider training and support for implementation of services, and offering LARC devices for free or low cost to patients at family planning clinics. This program garnered national attention for its outcomes, especially with regard to reducing unintended and teen pregnancy.¹² Although some experts disagree as to whether the pilot was the sole cause of this reduction, and advocates are exploring strategies to improve its model, many other states are interested in replicating this initiative. Several states have established pilot programs based on the Colorado program that fund LARC provision for specific populations or through specific agencies. Florida introduced a bill in 2018 that would have enacted a similar program through their department of health to train providers and provide LARC methods.¹³
- **Changes to insurance reimbursement in Medicaid or private plans related to immediate postpartum LARC:** Current public and private insurance policies may not appropriately reimburse providers and hospitals that provide a patient with LARC immediately after labor and delivery. Legislation to “debundle” reimbursement for IUDs and implants inserted in the immediate postpartum period can address this problem, removing financial barriers to hospitals and/or providers seeking to offer LARC to interested patients before leaving the hospital. In 2018, Utah enacted one such bill, **HB 12**.¹⁴

Analyzing Proposed Legislation

ADVOCATES CAN CONSIDER a few overarching questions to decide if and how to take action on LARC-related legislation — either publicly or behind the scenes.

WHAT ARE THE GOALS OF THE BILL?

It is important to assess the ultimate aim of the legislation, both as intended by its sponsors, champions, and supporters, and as actually written. Read the findings or introductory section to a bill; determine if the bill includes new funding and/or where it directs existing funding; and critically examine the language used in

11. General Appropriation Act of 2018 (2018). House Bill 2. New Mexico State Legislature

12. Colorado Department of Public Health and Environment (2017). Taking the Unintended Out of Pregnancy: Colorado’s Success with Long-Acting Reversible Contraception.

13. Long-Acting Reversible Contraception Pilot Program (2018). Senate Bill 1352. Florida State Legislature

14. Family Planning Services Amendments (2018) House Bill 12. Utah State Legislature

the bill to describe, regulate, or refer to contraception, counseling, and impacted populations. As with any legislation, understanding the ideology and values of the sponsor, co-sponsor(s), and major advocacy champions will also help you interpret the goals of the bill. Pay attention to the language they use to explain the bill and why they support it, analyze their traditional areas of focus on policy and public health, and evaluate the content and values of the coalition they have created in order to advance this legislation. Also, consider other bills introduced by the sponsor or their colleagues: do they align with the stated intent of the bill you are analyzing, or do they contradict it (e.g. mandated abstinence-based sex education or anti-abortion bills)?

DOES THE BILL SET OUT METRICS AND, IF SO, WHAT DO THEY INCENTIVIZE?

If the bill includes metrics, what they measure should be examined; the way(s) that the success, failure, or overall effectiveness of a policy is evaluated will have a significant effect on how it is implemented and how it impacts the populations it is intended to serve. For example, a program that measures the number of LARC devices placed and rewards or punishes providers as a result — implicitly or explicitly — creates a strong incentive for providers to urge patients to choose LARC, even when patients may prefer a different method. Not only is this kind of coercion unethical on its face, it also reinforces a deep distrust of public health efforts that will long outlast the method or the encounter. Likewise, tracking the number of LARC devices placed, with or without a target, creates different incentives than evaluating the ability of providers to offer these methods to all patients, both of which are different from looking for an overall reduction in unintended pregnancy. If the policy does establish metrics or include a plan for evaluation involving metrics, examine if and how it takes the patient perspective into account, such as measuring patient satisfaction or other patient-reported outcomes.

WHAT IS THE PLAN FOR IMPLEMENTING THE BILL, IF ANY?

For most legislation, and especially on an issue as complicated as health care provision, planning for implementation is key to the practical outcome of a policy. Often, legislation leaves these questions to a regulatory or other administrative body, but ideally, some guidance and resources for implementation will be included in the bill itself. Does the legislation specifically empower an agency to create regulations? Does it point to seeking out experts or best practices to establish regulations or procedures? Does it offer details on how to support provision of care, including training, counseling, and adapting administrative systems? Does it include a plan, or guidance, for guarding against coercion and/or support patient-centered counseling and care?

Identifying Red Flags

THERE ARE TIMES WHEN a contraceptive access bill may cause harm or operate contrary to the principles of reproductive autonomy and justice, whether inadvertently or deliberately. Look out for provisions that could impede a community's access to the full range of contraceptive methods, create or perpetuate obstacles when an individual wants to stop or switch methods, or result in patients being coerced into making a specific contraceptive choice. For example, a bill might include funding for IUD insertions but not for removals, appearing to increase contraceptive access but making device removal prohibitively expensive. The provisions below are red flags, indicating potential harm. It may be necessary to speak with other stakeholders, especially members of any community that would be impacted, to get their feedback and to bring them into conversation with legislators.

- **Funding that is targeted to provide LARC to a specific population.** Funding for LARC may have language that directs the devices towards specific populations, prioritizes access to LARC for specific populations, or calls for specific populations to receive information promoting LARC at the expense of comprehensive discussion of the full spectrum of birth control options. Oftentimes, these populations are targeted because lawmakers are looking for a solution to a larger problem; consider whether funding or the effort to implement a policy could be better spent addressing the underlying challenges that cause the problem policymakers are trying to solve.
 - > ***People Who Use Substances:*** As the opioid epidemic continues to be a major public health crisis, some policymakers see encouraging LARC use among people with substance abuse issues as a strategy to prevent unintended pregnancy and mitigate rates of neonatal abstinence syndrome (NAS). Ensuring that people with a substance abuse issue or who use drugs have access to contraception is important; limiting their ability to make their own informed decisions by promoting or only offering information on one specific method of contraception, or offering it for free or at a steep discount relative to other methods, is coercive. Any kind of substance abuse does not justify a provider or health care system removing a patient's autonomy.¹⁵
 - > ***People Who Are Incarcerated:*** Every incarcerated person has the right to access the full range of health care that they need, including reproductive health care. However, the reproductive health care available to people who are incarcerated is often limited and is offered in an environment that is inherently coercive. LARC

15 National Advocates for Pregnant Women (2016). Understanding Opioid Use During Pregnancy. http://advocatesforpregnantwomen.org/main/publications/fact_sheets/understanding_opioid_use_during_pregnancyrevised_2016.php.

access in jails and prisons must be offered as part of the full range of contraceptive methods, in conjunction with comprehensive, culturally competent contraceptive counseling and LARC device removal for any reason. People who are incarcerated also have the choice to not use contraception, which should be made clear during health care conversations. Further, because many formerly incarcerated people do not have a consistent source of health care, it is incumbent on public health officials to ensure that they know where to access reproductive health care and contraception upon release. Because LARC devices can only be removed by a provider, it is especially important that anyone who receives a LARC device while incarcerated has information on where to go to have it removed, and that that information is easily accessible, including after release.

JUSTICE NOW, an organization led by formerly incarcerated women, worked with **Planned Parenthood** and the **American Civil Liberties Union (ACLU)** to draft legislation requiring the state of **California** to offer all incarcerated people capable of becoming pregnant contraceptive counseling and methods before their release.¹⁶ Important elements of this bill, which became law in 2016, include the requirement that incarcerated people be able to obtain their choice of contraceptive method, that all types of FDA-approved contraceptive methods be offered, and that clinicians providing contraceptive counseling to incarcerated persons have received training and provide counseling that is unbiased, nondirective, and noncoercive.¹⁷

- > **Teenagers:** Young people are often policymakers' highest priority when it comes to preventing unintended pregnancy. However, initiatives that frame teen pregnancy as a social problem stigmatize young parents and their families, and many do not take a holistic approach toward understanding and addressing the lives of young people who become pregnant and how social determinants of health and their socioeconomic status may play into their decisions. Initiatives that focus on young people should include comprehensive sexuality education, respect young people's reproductive autonomy and decision-making, and avoid stigmatizing pregnant and parenting teens and their families.¹⁸

16 Justice Now. "About Us." <https://www.justicenow.org/what-we-do>. Accessed 9/9/18.

17 SB-1433 Incarcerated persons: contraceptive counseling and services. California Legislative Information Bill Text.

18. For more information on this, please visit <https://youngwomenunited.org/dismantlingteenpregnancyprevention/>

- **Funding that includes targets for increased LARC uptake.** Setting targets for numbers of LARC devices placed can pressure providers to prioritize LARC over other forms of contraception and lead to reproductive coercion and provider bias. For more information on appropriate performance measures, please see the Office of Population Affairs' Clinical Performance Measures for Contraceptive Care.¹⁹
- **Funding that does not provide access to removal.** LARC methods are unique in that, unlike other contraceptive methods, a provider must be involved when a patient chooses to discontinue use. Policies that will result in increased access to LARC device insertion should include similar measures for LARC device removal, including provisions to cover the cost of the removal and to ensure that providers are trained in the procedure.

Forming Your Strategy

ADVOCATES WHO ARE ASKED to provide input on a bill or are actively advocating for or against a particular LARC policy should start by engaging the community members who would be most impacted by the proposed policy and determine if advocacy coalition members have the expertise to understand the full implications of the policy. If not, advocates should seek out additional expertise to help determine an appropriate course of action and/or make recommendations on the bill. It can be difficult to strike the right balance of supporting increased access to contraception while ensuring that patient autonomy is respected; hearing from a wide range of experts can facilitate solutions and educate policymakers. State-based advocates, such as the local ACLU, Planned Parenthood, and NARAL affiliates, Kindred Partners of the Black Mamas Matter Alliance, Title X providers, reproductive justice and civil rights organizations, and patient advocates can all be sources of expertise, resources, and perspective to inform feedback on legislation. Contact the NWHN at schristopherson@nwhn.org and NIRH at lcroy@nirhealth.org for advice on specific bills in your community, and for assistance identifying advocates and experts in your state and on the national level.

19. Office of Population Affairs (2018). "Clinical Performance Measures of Contraceptive Care." <https://www.hhs.gov/opa/sites/default/files/clinical-performance-measures.pdf>

Conclusion

Removing the barriers that stand in the way of full access to the complete range of contraception, including LARC, is necessary and crucial. In this moment of increasing excitement and focus on these methods of contraception, advocates, providers, and legislators have an opportunity to learn lessons from our history and not repeat our mistakes. As these policies and our advocacy take shape, it is critical to maintain and center movement values: autonomy, respect, and trust in patients to decide what is right for them.

NIRH and the NWHN are grateful to **NARAL Pro-Choice Missouri, Planned Parenthood Federation of America, SisterSong Women of Color Reproductive Justice Collective,** and **SisterReach** for their thoughtful input and contributions to this report.

