Expanding Access To Long-Acting Reversible Contraceptives: A State-Level Budget Impact Model Of South Carolina

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CONCLUSIONS

- **Separate Medicaid reimbursement for desired immediate postpartum (IPP) long-acting reversible contraception (LARC) was associated with increased LARC uptake and fewer unintended pregnancies over 5 years.**
- **Over 5 years, the policy was linked to 2,863 additional IPP LARC insertions and 1,303 fewer unintended pregnancies.**
- **Although contraceptive spending increased by approximately $3.0 million, these costs were offset by lower pregnancy-, delivery-, and post-birth-related spending, generating $8.3 million in net savings ($2.74 saved per $1 spent).**
- **Findings remained robust across sensitivity analyses.**

OBJECTIVE

To estimate, from the South Carolina state perspective, the 5-year budget impact of separating Medicaid reimbursement for desired immediate postpartum LARC insertion from the global maternity fee.

INTRODUCTION

- Unintended pregnancy remains a clinical and economic challenge in the United States, and the postpartum period is a particularly important window for prevention.[1]
- Medicaid-enrolled individuals may face barriers to postpartum follow-up, making contraception access after discharge less reliable.[2]
- Desired immediate postpartum LARC can reduce gaps in contraceptive coverage because insertion occurs before hospital discharge and does not require a return visit.[3]
- Under bundled maternity payment, hospitals may face a financial disincentive to stock devices and provide IPP LARC because device and insertion costs are not separately reimbursed.[4]
- In 2012, South Carolina Medicaid changed its policy to reimburse hospitals separately for IPP LARC device and/or insertion.[5]

References
1. Schummers L, Hutcheon JA, Hernández-Díaz S, et al. Association of short interpregnancy interval with pregnancy outcomes according to maternal age. JAMA Internal Medicine. 2018;178(12):1661–1670. doi:10.1001/jamainternmed.2018.4696. 2. American College of Obstetricians and Gynecologists (ACOG). Medicaid Reimbursement for Postpartum LARC. ACOG; Updated November 2023. Accessed November 12, 2025. https://www.acog.org/programs/long-acting-reversible-contraception-larc/activities-initiatives/medicaid-reimbursement-for-postpartum-larc. 3. National Academy for State Health Policy (NASHP). State Medicaid Strategies to Support Postpartum Health with Contraceptive Care. Accessed November 12, 2025. https://nashp.org. 4. Rodriguez MI, Evans M, Espey E. Advocating for immediate postpartum LARC: increasing access, improving outcomes, and decreasing cost. Contraception. 2014;90(5):468–471. doi:10.1016/j.contraception.2014.07.001 . 5. Centers for Medicare & Medicaid Services. Contraception in Medicaid: Improving Maternal and Infant Health. Medicaid.gov. Accessed November 6, 2025. https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/maternal-infant-health-care-quality/contraception-medicaid-improving-maternal-and-infant-health. **6.** CDC. National Vital Statistics Reports. 2015;64(3). **7**. National Center for Health Statistics, final natality data. Available at: www.marchofdimes.org/peristats. Accessed March 20. 2024.

*Results updated post-abstract submission to reflect refined model assumptions; findings remain directionally consistent.

METHODS

Study Design

- We developed a state-level budget impact model (BIM) to estimate the financial consequences of separating Medicaid reimbursement for desired IPP LARC from the global maternity payment in South Carolina.

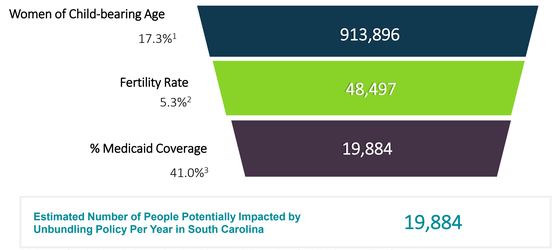
Perspective and Time Horizon

- The model was conducted from the South Carolina state perspective over a 5-year time horizon

Population

- The modeled population included Medicaid-enrolled women ages 18 to 44 giving birth in South Carolina. The eligible population was estimated using state birth statistics and Medicaid coverage rates (Figure 1).

Figure 1: Population Funnel Used to Estimate the Annual South Carolina Medicaid Birth Cohort Eligible



1. CDC Wonder: Single Race Population Estimates (South Carolina)[4]; 2. Derived from March of Dimes[5]; 3. Derived from March of Dimes[6]

Model Structure

Two scenarios were compared (Figure 2):

- Bundled reimbursement (IPP LARC included in maternity payment)
- Separate reimbursement (unbundled LARC device and/or insertion)

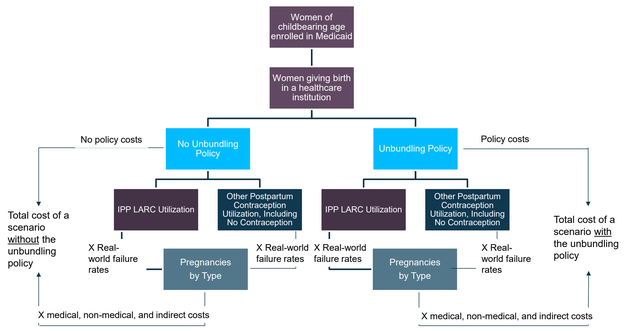
Postpartum contraceptive uptake and outcomes:

- Baseline contraceptive method mix from published literature
- IPP LARC uptake changes informed by South Carolina Medicaid and extrapolated over 5 years
- Method-specific failure rates applied to estimate unintended pregnancies
- Pregnancy outcomes (live birth, ectopic pregnancy, abortion) were assigned using published distributions

Costs included:

- Contraceptive costs (LARC devices, insertion/removal, other methods)
- Pregnancy (prenatal care, delivery, ectopic pregnancy, abortion)
- Postpartum care costs

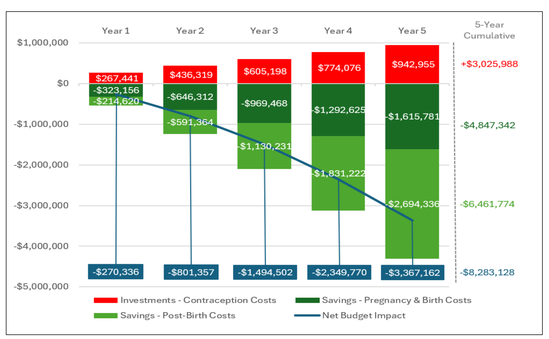
Figure 2: Budget Impact Model Comparing Bundled and Separate Reimbursement Scenarios



RESULTS

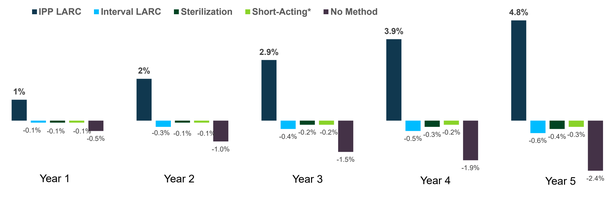
- IPP LARC use increased progressively under the unbundled scenario, by 4.8 percentage points by year 5 (Figure 4).
- Over the 5-year horizon, this translated into 2,863 additional IPP LARC insertions and 1,303 fewer unintended pregnancies.
- The clinical gains were accompanied by favorable budget impact. Separate reimbursement increased contraceptive expenditures by $3,025,988, but these upfront costs were offset by $11,309,116 in lower pregnancy-, delivery-, and post-birth-related expenditures, producing $8,283,128 in net savings over 5 years (Figure 3). This corresponds to $2.74 in net savings for each additional dollar spent on IPP LARC reimbursement.
- Savings were observed in every modeled year, showing that improved access to desired IPP LARC was associated with lower downstream state spending.

Figure 3: Five-year Budget Impact of Separate Unbundled Reimbursement for Desired IPP LARC



- In one-way sensitivity analyses, the results were most sensitive to the failure rate among women using no contraception, the annual increase in IPP LARC use after policy implementation, and the proportion of women of childbearing age in the population. Across all tested ranges, the unbundled scenario remained cost-saving.

Figure 4: Modeled Change in Postpartum Contraceptive Mix under Separate Reimbursement



*Short-acting includes injectable, oral contraception, patch, ring, and diaphragm methods

Limitations

- Findings are model-based estimates, not direct observations of policy effects.
- The model assumes gradual uptake of IPP LARC after unbundling and proportional declines in other methods or no method.
- Not all hospitals were assumed to implement IPP LARC at the same rate.
- The analysis considered adult enrollees on full Medicaid and is likely a conservative estimate of total benefit.

IMPLICATIONS

- Reimbursing desired IPP LARC separately from the global maternity fee functions as an access lever by removing point-of-care financing barriers.
- Increased access to IPP LARC was associated with greater postpartum use, fewer unintended pregnancies, and lower overall state spending over 5 years.
- The economic value of the policy is driven by avoided downstream costs (pregnancy-, delivery-, and post-birth-related), despite higher upfront contraception spending.
- For Medicaid decision-makers, this highlights a shift from short-term cost increases to longer-term budget efficiency.
- For hospitals and clinicians, separate reimbursement may enable device stocking and reduce operational barriers to program implementation.
- As many states use similar Medicaid maternity payment structures, the policy relevance extends beyond South Carolina, while still requiring local adaptation.