The Problem

- Half of all pregnancies are unintended (Guttmacher, 2013)
- Rates of unintended pregnancy (UP) highest among low-income, young women (Guttmacher, 2013)
- Utilization of LARC lowest among young women and minorities (CDC, 2012)
- UP cost $11.1 B in 2006 (Guttmacher, 2013)
- Short acting contraception (SARC) including pill and condom, is less effective than LARC (IUD) due to increased reliance on the user (Trussell, 2004)

Purpose of the Project

- Goal: evaluate economic impact of a modest increase in LARC uptake on Medicaid expenditures in RI

Assumptions

- Compared current to 3 hypothetical scenarios
  - 10% women on no method → LARC
  - 10% women on SARC → LARC
  - 5% women on no method and 5% on SARC → LARC
- Defined contraception as
  - LARC = IUD
  - SARC = pill, injection
  - No method = none, rhythm, withdrawal

Key Finding

- Medicaid can save almost $1 M if a small percentage (10% over 3 years) of women switch to LARC from no method and SARC methods. This is a conservative estimate because of the small switch over 3 years, and because we used conservative estimates of costs and savings.

Projected Savings from Averted UP

- Multiplied number of UPs by average cost of UP to get projected savings from averted UP
- Calculated number of UPs prevented by multiplying number of women on contraception by probability of having UP in current and hypothetical scenarios
- Used DRG codes to estimate range of average Medicaid reimbursement for 3 birth outcomes (Table 1)
- Calculated average cost of UP by weighting the average Medicaid reimbursement for 3 birth outcomes: live and uncomplicated, LBW, and spontaneous abortion (Table 2)
- Takeaway: Scenario 1 offers highest potential savings, scenario 2 offers lowest potential savings, and scenario 3 offers middle-of-the-road savings (Table 3)
Projected Medicaid Costs of Contraception

- Calculated annualized cost of contraceptives to compare those of different lifespans (Table 4)
- Compared Medicaid’s current contraceptive costs to costs in hypothetical scenarios (Table 5)
- Takeaway: Contraceptive costs in scenario 2 and 3 are lower than in the current scenario because annualized cost of IUDs is less than annualized cost of short acting methods (pill and injection) (Table 5)

Projected Net Savings

- Subtracted estimated costs from estimated savings to get projected net savings
- Calculated net savings over one year
- Takeaway: Results are sensitive to varying cost of IUDs, cost of birth outcomes, and proportion of women switching to LARC. However, conclusion is same: scenario 1 has highest net savings, scenario 2 has lowest net savings, and scenario 3 offers savings in the middle. (Table 6)

Financial Projections

- Modeled what happens when the 10% switch of women to LARC occurs over 3 years, instead of 1 year – a more conservative and feasible scenario
- Assumed some women switch from SARC and some from no method to LARC
- Included resources needed for education and outreach to providers and women
- Takeaway: Medicaid can save almost $1 M over three years if a small percentage of women switch to LARC from no method and SARC methods. This is a conservative estimate because of the small switch over three years, and because we used conservative estimates of costs and savings. (Table 7)