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INSIDE

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Research Backs Effectiveness of Putting Implants in Place

New research indicates that the risk of luteal phase pregnancy following any-cycle-day insertion of contraceptive implants with negative pregnancy testing is low, regardless of menstrual cycle timing, recent contraceptive use, or use of emergency contraception.[1]

To perform the study, researchers at the University of Colorado assessed a retrospective cohort of young women receiving contraceptive implants at BC4U clinic at the Children's Hospital Colorado, an adolescent Title X clinic. Patients with negative pregnancy tests were eligible for same-day insertion, regardless of cycle day, contraceptive use, or last intercourse.

To perform the analysis, the researchers computed luteal phase pregnancy rates for those within manufacturer insertion guidelines (defined as five or less days of menstrual onset or seven or less days post-discontinuation of hormonal contraception), as well as those outside the guidelines. For placements outside guidelines, instructions were given to use back-up method for seven days, take a pregnancy test in two to four weeks, and return to the clinic if they suspected they were pregnant.

"OUR STUDY SHOULD REASSURE PROVIDERS THAT USING THIS 'ANY CYCLE DAY' PROTOCOL APPROACH TO CONTRACEPTIVE IMPLANT INSERTION IN ADOLESCENTS AND YOUNG WOMEN DOES NOT INCREASE THE RISK OF LUTEAL PREGNANCY." — MOLLY RICHARDS, ASSISTANT PROFESSOR, PEDIATRICS-ADOLESCENT MEDICINE, UNIVERSITY OF COLORADO

Scientists reviewed medical records for last menstrual period, current hormonal contraception, emergency contraception provision, and pregnancy tests administered at 12 weeks or less post-implant placement, or later evidence of pregnancy.

For patients with positive pregnancy tests or reports, the analysis used standard obstetrical dating (last

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menstrual period and ultrasound) to determine if conception occurred at two weeks or above of implant placement.

Researchers estimated the occurrence of luteal phase pregnancy when following the manufacturer's guidelines to be 0.5%. This study was designed to demonstrate no increased incidence of luteal phase pregnancy for insertions outside the manufacturer's guidelines, with an acceptable risk difference of 0.7%.[1]

Of 3,180 documented insertions, 1,868 (58.8%) were outside recommended guidelines, the analysis indicated. Women with insertions within guidelines were older (20.2 vs. 19.3 years; $P < 0.001$) and more likely to be white (40.4% vs. 29.5%; odds ratio [OR], 1.6; 95% confidence interval [CI], 1.4-1.9). Definitive pregnancy data were documented for 1,726 patients: 660 (50.3%) in the within-guidelines group, and 1,066 (57.0%) in the outside guidelines group. Rates of luteal phase pregnancy were 0.3% (2/660; 95% CI, 0.0-1.1%) in the within-guidelines group and 0.9% (10/1,066; 95% CI, 0.5-1.7%) in the outside guidelines group.

"Adopting a protocol of contraceptive implant placement that includes insertion on any cycle day with a negative pregnancy test, and emergency contraception as indicated, does not increase the risk of luteal phase pregnancies, even in a young population with complex reproductive behaviors and challenging historical narratives," the researchers concluded.

Product labeling for the contraceptive implant states that insertion occur within five days of menses or seven or less days from discontinuation of another hormonal method, and with a negative urine pregnancy test. These guidelines can be challenging to same-day implant initiation for adolescents due to teens' inconsistent contraceptive use, menstrual cycle irregularities, and problems with accessing appointments during regular clinic hours.

Offering same-day initiation is important in the adolescent and young adult populations because research indicates rates of follow-up may be low, says lead researcher **Molly Richards**, MD, assistant professor, pediatrics-adolescent medicine, at the University of Colorado School of Medicine.

According to the *U.S. Selected Practice Recommendations for Contraceptive Use*, providers reasonably can determine if a patient is not pregnant if she exhibits no symptoms or signs of pregnancy and meets any one of the following criteria:

- has not engaged in intercourse since last normal menses;
- has been using a reliable contraception method properly and consistently;
- is within seven days after normal menses;
- is within four weeks postpartum (non-lactating);
- is within the first seven days post-abortion or miscarriage;
- is fully or nearly fully breastfeeding, amenorrheic, and less than six months postpartum.[2]

This approach can be challenging with adolescents, who are more likely to experience irregular menses, or to be unsure of when their last menses occurred, according to Richards.

"Our study should reassure providers that using this 'any cycle day' protocol approach to contraceptive implant insertion in adolescents and young women does not increase the risk of luteal phase pregnancy," Richards says.

"Overall, this is a useful and important article, and certainly applies to pills, patch, ring, and implants," says **Andrew Kaunitz**, MD, University of Florida Research Foundation Professor and associate chairman of the depart-

ment of obstetrics and gynecology at the University of Florida College of Medicine-Jacksonville. "Given the high stakes with IUDs (e.g., the negative consequences when we place an IUD in a woman later found to be pregnant), however, I am not sure I would be comfortable concluding that this data reassures us that an any-day start approach is appropriate with IUDs."

According to the Family Planning National Training Center's *Contraceptive Access Change Package*, family planning providers should develop systems for same-visit provision of all contraceptive methods. By doing so, providers can make it possible for all patients, including women who choose long-acting reversible contraceptives such as intrauterine devices (IUDs) and implants, to leave their visit with their selected contraceptive method.[3]

Clinicians should offer women the option to begin birth control at the time of the office visit rather than waiting for her next menses, or returning for another appointment.[4] There is no medical reason for providers to routinely require multiple visits to initiate any contraceptive method if the *U.S. Selected Practice Recommendations for Contraceptive Use* criteria for excluding pregnancy are met.[2]

Although it has been common practice to require multiple appointments for starting methods such as the IUD or implant, published research and guidance from the CDC and the American College of Obstetricians and Gynecologists indicate that clinicians can initiate and provide the patient's method of choice in a single visit, unless additional testing is medically indicated.[5,6]

Same-day initiation of contraception, known as Quick Start, is now an accepted practice among family planners. Almost 90% of respondents to the 2015 *Contraceptive Technology Update* Contraceptive Survey reported that their facilities offered the program for combined hormonal methods. This statistic compares favorably with the 45% of adolescent health providers who reported Quick Start use in 51 health centers throughout the United States with high rates of teen pregnancy.[7] ■

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Researchers, Advocates Seek Pathways to Easing Access to Medication Abortion

Considering medical pregnancy termination through an over-the-counter regulatory lens

A new analysis of medical literature examined the evidence needed to determine whether women can safely access nonprescription medication abortion without a prescription.[1] Considering medical pregnancy termination through an over-the-counter regulatory lens clarifies critical evidence gaps, researchers noted.

Medication abortions accounted for 31% of all nonhospital abortions in 2014, and for 45% of abortions before nine weeks' gestation.[2] In the 16 years since the United States approved mifepristone for abortion, research and clinical experience have underlined the efficacy and safety of the mifepristone/misoprostol regimen for the procedure. However, many women who could benefit from mifepristone still do not have access to it because of multiple barriers, including FDA distribution and provider requirements.[3]

One key step in making medication abortion more accessible is removing unnecessary dispensing restrictions, says **Kelly Blanchard**, president of Ibis Reproductive Health, an international nonprofit research organization for reproductive health.

Mifepristone is not available in pharmacies like other prescription medicines, Blanchard explains. Its access is restricted by an FDA regulation mechanism known as Risk Evaluation and Mitigation Strategy (REMS), which normally is for medicines that are dangerous or require more complicated screening to use safely, she notes.

"Though mifepristone is safe and effective, the REMS require that it can only be dispensed to patients in clinics, medical offices, and hospitals by or under the supervision of a certified provider, and that each person taking mifepristone must be given a medication guide and sign an FDA-approved patient agreement," Blanchard says. "Years of experience and rigorous research in the U.S. and around the globe show mifepristone is safe and effective, and there is no medical justification for the REMS."[4]

Eliminating the REMS, which places medically unnecessary burdens on providers and patients, to reflect the safety and efficacy of mifepristone would help improve access for all people, regardless of income or ZIP code, Blanchard argues.

"Medication abortion has the potential to fill gaps in abortion access, since it doesn't require the facilities that other abortion procedures require, and removing the REMS would hopefully be a first step toward easier access and fewer restrictions," she says.

In 2016, the FDA approved updated labeling for mifepristone (Mifeprex) to reflect the most current clinical practices and safety and efficacy data. The drug's new label reduces the size of the initial dose to 200 mg and extends the window for taking it to 70 days since the first day of a woman's last menstrual period. The updated label also allows the second drug in the medication abortion regimen, misoprostol, to be taken "at a location appropriate for the patient." *(For previous* Contraceptive Technology Update *reporting on this subject, please visit: http://bit.ly/2qL2WGP.)*

Researchers also are documenting the potential for even less supervision, including showing the safety and effectiveness of telemedicine and other innovative ways to access medication abortion, Blanchard says.

Access to abortion is difficult for many U.S. women. A national survey conducted in 2008 found that 31% of patients in rural areas traveled more than 100 miles for abortion services.[5] Since then, states have enacted even more restrictions on abortion, including limits on the construction of facilities, the qualifications for clinicians, and affiliated medical procedures.

According to a new analysis from the Guttmacher Institute, the number of U.S. abortion-providing facilities declined from 1,720 to 1,671 between 2011 and 2014. Meanwhile, the number of clinics providing abortion services declined from 839 to 788 over the same period. In 2014, 90% of all U.S. counties lacked a clinic, and 39% of women of reproductive age lived in those counties.[2]

Telemedicine provisions of

States That Require Clinician Presence

The following states require prescribing clinicians to be physically present during medication abortion procedures:

- Alabama
- Arizona
- Arkansas
- Indiana
- Kansas
- Louisiana
- Michigan
- Mississippi
- Missouri
- Nebraska
- North Carolina
- North Dakota
- Oklahoma
- South Carolina
- South Dakota
- Tennessee
- Texas
- West Virginia
- Wisconsin

SOURCE: Guttmacher Institute. State Laws and Policies. Medication Abortion. Available at: http://bit.ly/2qVoDUq. Accessed May 18, 2017.

medication abortion has been shown to be safe and effective.[3] A 2014 practice bulletin from the American College of Obstetricians and Gynecologists noted that the procedure can be provided safely and effectively via telemedicine with a high level of patient satisfaction.[6] However, 19 states require that the clinician providing a medication abortion be present during the procedure, thereby prohibiting the use of telemedicine to prescribe medication for abortion remotely.

"We look forward to helping to both make the case and build the evidence base so women can access medication abortion in a way that meets their needs, including potentially over the counter, and can decide for themselves whether to have an in-clinic or home abortion, with no fear of legal repercussions," Blanchard says. ■

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Women with Predisposition to Fractures May Benefit from Hormone Therapy

Researchers discovered that women who are genetically at the highest risk of fracture risk can enjoy the greatest protection from fracture when they use hormone therapy

Women at the highest genetic risk for fracture may benefit the most from hormone therapy, according to data from a new study.[1]

Previous research has shown the protective effect of menopausal hormone therapy on bone.[2] However, scientists from four institutions wanted to explore whether genetic susceptibility modifies the association of hormone therapy and fracture risk.

To conduct the current analysis, the team constructed two weighted genetic risk scores, based on 16 fracture-associated variants and 50 bone mineral density variants. The researchers included 9,922 genotyped white postmenopausal women ages 50-79 from the Women's Health Initiative hormone therapy randomized trials in their analysis.

"We found that women who are genetically at the highest fracture risk can enjoy the greatest protection from fracture when they use hormone therapy," says **Heather Ochs-Balcom**, PhD, head of the research team and associate professor of epidemiology and environmental health in the University at Buffalo's School of Public Health and Health Professions.

Further studies on gene therapy interaction are needed to evaluate the advantages of targeted interventions based on genetic profiles, notes **Youjin Wang**, PhD, postdoctoral fellow at the National Cancer Institute's clinical genetics branch. Wang, lead author of the paper, was a doctoral

EXECUTIVE SUMMARY

Women at the highest genetic risk for fractures may benefit most from hormone therapy, according to a new study.

- The initiation of hormone therapy is considered an acceptable option for women up to 59 years of age or within 10 years of menopause and those who complain of moderate to severe menopausal symptoms.
- Clinicians can use a fracture risk assessment tool to predict if a patient is at risk for bone fracture in the next 10 years. The tool is based on such risk factors as age, body mass index, history of fracture, daily alcohol intake, and whether a patient smokes, and suffers from rheumatoid arthritis or any other secondary causes of osteoporosis.

candidate in epidemiology and environmental health at the University at Buffalo.

Evaluate Risks, Benefits

In 2002, the Women's Health Initiative reported an increased risk of breast cancer, heart disease, stroke, and blood clots with the use of combined estrogen plus progestin hormone therapy. In the years following those results, further research has indicated that the type of therapy (estrogen or estrogen plus progestin), how it is taken, and the timing of treatment initiation (pre- or post-menopause) produce different benefits and side effects.

The risk of side effects (such as heart attack, stroke, blood clot, or breast cancer) with hormone therapy in healthy women 50-59 years of age is low. In contrast, using hormone therapy for a long time or starting treatment when women are several years beyond menopause is associated with a higher risk of such side effects.[3]

The initiation of hormone therapy is considered an acceptable option for patients up to 59 years of age or within 10 years of menopause and healthy women who suffer from moderate to severe menopausal symptoms, according to a 2012 joint statement issued by the North American Menopause Society, the American Society for Reproductive Medicine, and the Endocrine Society.[4]

The World Health Organization (WHO) developed a fracture risk assessment tool called FRAX, which can help clinicians predict if a patient is at risk for bone fracture in the next 10 years. Clinicians can use FRAX to decide if a patient is at high risk for fracture if her initial scan indicates low bone mass. WHO built the tool using such risk factors as age, body mass index, history of fracture, daily alcohol intake, and whether a patient smokes, suffers from rheumatoid arthritis, or exhibits any other secondary causes of osteoporosis. *(Access it at: http://bit.ly/2qeeb9d.)*

The U.S. Preventive Services Task Force recommends screening women 65 years of age and older for osteoporosis, since gender and age are the leading risk factors. Younger women who present with certain risk factors, such as a small body frame, a history of fractures, or taking medication that thins bones, also should receive screening.[5]

Recent research indicates that too few women at high risk for osteoporosis undergo testing for the condition, while too many women at low risk receive screening.[6]

For women at risk of osteoporosis, providers can offer the following tips to patients to help them improve bone health:

- Take medications to strengthen bones, and avoid medications that can weaken bones;
- Consume a healthy diet rich in calcium and vitamin D;
- Perform regular weight-bearing exercises;
- Do not smoke;
- Limit alcohol intake. ■

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Talk to Young Adults About Importance of Sexually Transmitted Infection Testing

When it comes to sexually transmitted infections (STIs), young adults are most at risk, with one in two sexually active people contracting an infection by age 25.[1] The creators of a new national campaign, "YES Means TEST," are spreading the word about the importance of STI testing in this at-risk population.

Launched in April 2017 by the American Sexual Health Association (ASHA), the campaign seeks to normalize STI testing so young people will view it as a natural part of saying "YES" to sexual activity. The campaign features online advertising, media efforts, and links with advocacy groups. All activities direct people to www.YESmeansTEST.org to help people find nearby clinics to receive confidential and free/low-cost STI testing.

There are several reasons young people aren't getting tested, says **Lynn Barclay**, ASHA president and chief executive officer. They often are in denial about the risk of STIs, aren't educated about their harmful effects, or may be too embarrassed to discuss the topic, she notes.

"We've got to reverse that stigma so people, especially young women, feel empowered to take ownership of their sexual health," Alexander said at the campaign launch.

Providers can join in promoting testing by posting a free, downloadable document, available at http://bit.ly/2qfY3SQ, in their facilities.

Condoms must be a part of any discussion with adolescents, according to **Robert Hatcher**, MD, MPH, professor emeritus of gynecology and obstetrics at Emory University School of Medicine in Atlanta.

"We know the two most common reasons people do not use a condom: One, no condom is available, and two, a couple thinks they are not at risk for pregnancy or infection," Hatcher observes. "Consistent and correct use of condoms is extremely important if our nation is to prevent the myriad sexually transmitted infections afflicting young adults."

Chlamydia and gonorrhea are the most prevalent STIs among young people. In 2015, there were 981,359 reported cases of chlamydia infection among Americans 15-24 years of age, representing 64.3% of all reported cases.[2]

In 2015, rates of reported gonorrhea cases were highest among young adults and adolescents, with the highest rate among females 20-24 years of age (546.9 cases per 100,000) and 15-19 years of age (442.2 cases per 100,000).

For men, the rate also was highest among those 20-24 years of age (539.1 cases per 100,000) and 25-29 years of age (448.8 cases per 100,000).[2]

Since STI symptoms may go undetected, many may go without testing. Untreated STIs can cause pelvic inflammatory disease (PID), a serious condition for women. It is estimated that one in eight women with a history of PID experience difficulties conceiving.[3] *(For more information on this subject, please visit: http://bit.ly/2qdTJFv.)*

"YES Means TEST" was designed primarily to reach women 18-24 years of age who are sexually active but do not seek regular STI testing. The CDC recommends annual chlamydia and gonorrhea screenings for this group.[4]

EXECUTIVE SUMMARY

The creators of a new national campaign are spreading the word out about the importance of testing for sexually transmitted infections (STIs) in adolescents and young adults.

- Young adults are most at risk for STIs, with one in two sexually active people contracting an infection by age 25.
- Chlamydia and gonorrhea are the most prevalent STIs among young people. In 2015, there were 981,359 reported cases of chlamydia infection in the United States among people 15-24 years of age, representing more than 60% of all reported chlamydia cases. In that same year, rates of reported gonorrhea cases were highest among adolescents and young adults.

Don't Forget Men

An examination of national chlamydia and gonorrhea case report data in adolescents 15-19 years of age indicates that after years of decreases, chlamydia and gonorrhea rates are increasing among adolescent males, while rates continue to decline among their female peers.[5] What factors may have led to this finding?

Findings from the CDC's STD Surveillance Report has shown that increases in overall number of reported cases of chlamydia and gonorrhea in recent years have largely been driven by men, notes **Elizabeth Torrone**, PhD, an epidemiologist in the CDC's division of STD prevention. Because most chlamydial infections are asymptomatic, the number of infections that are reported can be affected by how many people receive screening, as well as the expanded use of more sensitive diagnostic tests, she says.

"We are not yet certain why reported cases of chlamydia has increased among men, but increased implementation of *STD Screening Recommendations*, which include annual syphilis, chlamydia, and gonorrhea tests for all sexually active men who have sex with men, as well as evolving testing strategies that include

more extragenital screening, may be increasing detection of chlamydial infections," Torrone explains. ■

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Hot Flashes Appear Linked to Cardiovascular Changes

New data suggest that, particularly for younger midlife women, frequent hot flashes may indicate emerging vascular dysfunction that can lead to heart disease.[1]

Findings suggest that early onset of menopausal symptoms is associated with dysfunction of the endothelium. Researchers studied endothelial dysfunction by assessing flow-mediated dilation, a noninvasive ultrasound measure of how well the vessel dilates in response to pressure on the wall of the blood vessel. This is the first study to test the relationship between physiologically assessed hot flashes and endothelial cell function.

Rebecca Thurston, PhD, professor of psychiatry at the University of Pittsburgh, and colleagues examined associations between menopausal symptoms and risk for cardiovascular disease complications among postmenopausal women who took part in the National Heart, Lung, and Blood Institute Women's Ischemia Syndrome Evaluation study, designed to assess women with suspected ischemic heart disease. The authors included 254 postmenopausal women with signs and symptoms of ischemic heart disease in their analysis.

The analysis suggested that women who experience hot flashes before age 42 were more likely to exhibit lower flow-mediated dilation, suggesting adverse endothelial changes as well as higher mortality from heart disease.[1]

Researchers documented the effect of hot flashes on the ability of blood vessels to dilate only in the younger percentile of women in the sample. The analysis found no association in women 54-60 years of age, indicating that early occurring hot flashes may be those most relevant to heart disease risk. The associations were independent of other heart disease risk factors.

Hot flashes have been perceived as pesky symptoms that can persist for several years near the final menstrual period, affecting quality of life for many women, Thurston notes.

"However, we now know that these symptoms persist far longer and often start earlier than we previously thought," Thurston said in a statement accompanying the analysis publication. "Our research also suggests that for some women, particularly

EXECUTIVE SUMMARY

New data suggest that, particularly for younger, midlife women, frequent hot flashes may indicate emerging vascular dysfunction that can lead to heart disease.

- Findings from the study, conducted by a team of University of Pittsburgh School of Medicine researchers, suggest that early onset of menopausal symptoms is associated with dysfunction of the endothelium.
- The scientists studied endothelial dysfunction by assessing flow-mediated dilation, a noninvasive ultrasound measure of how well the vessel dilates in response to pressure on the wall of the blood vessel. It's the first study to test the relationship between physiologically assessed hot flashes and endothelial cell function.

for younger midlife women, menopausal symptoms might mark adverse changes in the blood vessels during midlife that place them at increased risk for heart disease."

Heart Disease Risk

These findings may provide critical information to healthcare providers working to assess heart disease risk in menopausal women, according to the North American Menopause Society (NAMS). Seventy percent of women report hot flashes, with about one-third describing these episodes as frequent or severe.[2] More recent data suggest hot flashes may begin earlier than previously thought, and persist for a decade or longer.[3]

"Hot flashes are not just a nuisance, they have been linked to cardiovascular, bone, and brain health," **JoAnn Pinkerton**, MD, NAMS, executive director of NAMS, said in a statement after the study was published. "In this study, physiologically measured hot flashes appear linked to cardiovascular changes occurring early during the menopause transition."

Heart disease is a concern for American women; it is the leading cause of death for them. An estimated 289,000 women died from heart disease in 2013, representing about one in four of every female death.[4] Although awareness of the disease in women has been raised over the past decade, only about half recognize that heart disease is the leading cause of death.[5]

Broken down by race, heart disease is the leading cause of death for African-American and white women in the United States. Cancer and heart disease cause roughly the same number of deaths among Hispanic women each year. Heart disease is the second-leading killer among American Indian, Alaska Native, and Asian or Pacific Islander women.[6]

Identify Risks

The National Heart, Lung, and Blood Institute estimates that 80% of women 40-60 years of age exhibit one or more of the modifiable risk factors for heart disease: high blood pressure, high cholesterol, overweight/obesity, physical inactivity, diabetes, and smoking. Experts estimate 60% of women 20-39 years of age demonstrate one or more of these risk factors. With obesity rates climbing among younger women, public health officials warn of the risk of higher rates of heart disease in later years.

"While more work needs to be done to confirm our findings, our research could, one day, help us predict the midlife women who might be at increased risk for cardiovascular disease so that we proactively target these women for early prevention strategies," Thurston said. ■

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Report: Hepatitis C Rates on the Rise Among Reproductive-aged Women

The CDC reports the number of hepatitis C virus (HCV) cases reported in reproductive-aged women in the United States has increased substantially in recent years.[1]

The incidence of HCV infection has increased among young people who inject drugs, about half of whom are women of reproductive age, the data indicate. This raises concerns about the heightened risk of HCV transmission from pregnant women to their infants.

To assess the extent of HCV infection in reproductive-aged and pregnant women, as well as their infants, researchers studied the CDC's National Notifiable Diseases Surveillance System (NNDSS) and the Quest Diagnostics Health Trends database, two of the largest

population data sets available in the United States.

According to the analysis, HCV cases doubled among reproductive-aged women between 2006 and 2014, rising from 15,550 to 31,039. By applying the Quest HCV infection rate among pregnant women to annual live births, about 29,000 HCV-infected women give birth each year, the analysis indicates. This finding translates into 1,700 infants acquiring HCV each year; however, only 200 childhood cases are reported to the NNDSS each year, suggesting that cases are underreported.

Providers should incorporate these findings in developing HCV screening programs for pregnant women, researchers noted. ■

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WASHINGTON WATCH

House Healthcare Bill Would Undermine Reproductive Health

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As conservatives in Congress and the Trump administration plow forward on efforts to repeal and replace much of the Affordable Care Act (ACA), one pattern that has become clear is that their efforts would directly and indirectly imperil coverage for and access to reproductive healthcare under Medicaid and private insurance. The opening bid on those efforts — the American Health Care Act, which passed the House of Representatives on May 4 — is frightening in its potential impact.[1]

The most prominent effect of the House-passed bill would be to eliminate health insurance coverage for millions of U.S. residents, 14 million by 2018 and 24 million by 2026, according to an analysis of an earlier draft of the bill by the Congressional Budget Office (CBO).[2] That would mean the loss of coverage for family planning services and supplies, maternity care, sexually transmitted infection testing and treatment, cervical cancer screening, and numerous other important services.

Medicaid Takes Largest Hit

Medicaid would bear the brunt of these losses. The legislation effectively would phase out the ACA's Medicaid expansion for low-income adults with incomes up to 138% of the federal poverty level by scaling back federal reimbursement to states. More broadly, the legislation would overhaul Medicaid financing by imposing a so-called per capita cap: a maximum amount the federal government would reimburse states per enrollee, designed so that federal spending would be progressively lower, compared to expected growth in Medicaid's costs. Instead, states could choose to receive a so-called block grant, which would scale back federal spending even more sharply while allowing states to ignore a host of federal Medicaid protections, including many related to family planning and maternity care. Combined, these changes would reduce federal investment in Medicaid by $839 billion over the first decade and far more over time, according to the CBO analysis.[2] That would force states to scale back eligibility, benefits, and payments to providers unless states were somehow able to make up the difference.

Private insurance also would be hit hard. The House legislation would restructure current tax credits that make ACA marketplace coverage affordable for low-income residents. The revised credits could be used to buy coverage anywhere in the individual insurance market and would be available to more people than under the ACA. However, unlike today, they would not properly adjust for income or local costs, and they would be less generous than they are today for most recipients, particularly low-income, rural, and older Americans. Millions would lose coverage.

At the demand of House conservatives, the bill also would allow states to opt out of several key ACA protections for private insurance. That includes the essential health benefit package, which requires individual market plans to cover 10 core categories of care. Coverage for maternity care is on that list and has been a frequent target of criticism by conservatives. Prior to the ACA, the

vast majority of individual market insurance plans excluded maternity coverage, or covered it only at an additional high premium and with strict limitations.[3] States also would be allowed to ease ACA prohibitions on charging higher premiums based on health status. These two provisions combined would undermine the ACA's popular protections for people with pre-existing conditions.

What About Reproductive Health?

On reproductive health specifically, the bill includes a provision to exclude Planned Parenthood affiliates from receiving reimbursement for care provided to Medicaid enrollees (for a one-year period, although conservatives surely would look to extend that ban later). Moreover, it includes multiple provisions that would undermine private insurance coverage of abortion.

Most notably, it would prevent the use of federal tax credits to purchase any plan that covers abortion (except in a few extreme circumstances); because almost everyone buying individual market insurance would be eligible for several thousand dollars in tax credits, this effectively would eliminate abortion coverage in that market.

The bill does not directly affect the ACA's contraceptive coverage guarantee or its broader requirement for plans to cover a wide range of preventive services without patient out-of-pocket costs. Repealing these provisions likely would violate the arcane rules around "budget reconciliation," a special procedure that allows for bills to pass the Senate with a simple majority, rather than the 60 votes needed to overcome potential filibusters. Under those rules, all provisions in the bill must have a direct impact on the federal budget or risk removal.

However, on the same day the House passed its bill, President Trump used an executive order on "religious liberty" to signal his administration's intent to undermine the contraceptive coverage guarantee through new regulations.[4] At publication of this column, it is not yet clear when that regulatory action will happen or what form it will take.

Watch Legislation Closely

The House bill's prospects in the Senate are unclear. Numerous senators, governors, and outside groups across the political spectrum have criticized the legislation. Even within the 52 members of the Senate Republican caucus, there are stark disagreements between moderates and conservatives, and between senators representing states with and without Medicaid expansions.

If the Senate manages to craft and approve its own version of a repeal-and-replace bill, it is far from certain that the House will be able to muster the votes to approve whatever changes the Senate makes. ■

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COMING IN FUTURE MONTHS

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- Are more women accessing postpartum LARC methods?
- Dual-purpose vaginal ring moves to clinical trial
- Treating polycystic ovary syndrome may prevent later infertility

CME/CE OBJECTIVES

After reading *Contraceptive Technology Update*, the participant will be able to:

1. identify clinical, legal, or scientific issues related to development and provisions of contraceptive technology or other reproductive services;
2. describe how those issues affect services and patient care;
3. integrate practical solutions to problems and information into daily practices, according to advice from nationally recognized family planning experts;
4. provide practical information that is evidence-based to help clinicians deliver contraceptives sensitively and effectively.

CONTRACEPTIVE TECHNOLOGY UPDATE®

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CME/CE QUESTIONS

1. **Which of the following criteria is *not* listed by the *U.S. Selected Practice Recommendations for Contraceptive Use* to be reasonably certain that a woman is not pregnant?**

   a. Has not engaged in intercourse since last normal menses
   b. Has been correctly and consistently using a reliable method of contraception
   c. Is within seven days after normal menses
   d. Is within six weeks postpartum (non-lactating)

2. **What is the approved initial dose for the medication abortion drug mifepristone?**

   a. 200 mg
   b. 300 mg
   c. 400 mg
   d. 500 mg

3. **In what time period can FRAX, a fracture risk assessment tool, help further predict a person's risk of bone fracture?**

   a. In the next three years
   b. In the next five years
   c. In the next seven years
   d. In the next 10 years

4. **What are the two most common sexually transmitted infections in adolescents?**

   a. Chlamydia and syphilis
   b. Gonorrhea and syphilis
   c. Chlamydia and gonorrhea
   d. Chlamydia and hepatitis C