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INSIDE

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USPSTF Issues Final Guidance for Cervical Cancer Screening

Women ages 30-65 can choose high-risk HPV screening or cotesting every five years

The US Preventive Services Task Force (USPSTF) has issued final recommendations for cervical cancer screening, calling for women ages 21 to 29 to be tested with cervical cytology every three years. For women 30 to 65 years of age, the new guidance calls for screening with the Pap test every three years, or with the high-risk human papillomavirus (hrHPV) test alone or with both tests every five years.[1]

"THE CURRENT GUIDELINES PRESERVE THE GREATEST RANGE OF CHOICES FOR PRACTITIONERS AND PATIENTS."

The new guidance applies to women with a cervix who do not have any signs or symptoms of cervical cancer and does not depend on their sexual history or whether they have received the HPV vaccine. The recommendation does not include women with certain cervical cancer risk factors, such as HIV infection, immunocompromise, exposure to diethylstilbestrol in utero, and prior treatment of a high-grade precancerous lesion. Clinicians should provide individualized follow-up for these women.[1]

As in its 2012 guidance, the task force does not recommend cervical cancer screening for the following groups: women younger than 21 years of age, women older than 65 years of age who have received adequate screening previously and do not have a high risk for the disease, and women who have undergone uterus and cervix removal and who do not have a history of either cervical

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cancer or a high-grade precancerous lesion.[1]

In its recommendations on the subject, the task force guidance recommends that women ages 30 to 65 have the choice of screening using the hrHPV test and Pap test together every five years, which increases the interval between screenings. For the first time, the new guidance includes the choice of receiving hrHPV testing alone every five years.

"The current guidelines preserve the greatest range of choices for practitioners and patients; in the sense that both will benefit," says obstetrician/gynecologist **Lee Learman**, MD, PhD, senior associate dean for graduate medical education and academic affairs and professor at Florida Atlantic University's Schmidt College of Medicine and lead author of an accompanying editorial to the published guidance.[2] "More efficient cervical cancer screening every three to five years will liberate time at the annual visit to discuss prevention of other cancers and chronic diseases that disproportionately burden women."

A joint statement from the American College of Obstetricians and Gynecologists, the American Society for Colposcopy and Cervical Pathology, and the Society of Gynecologic Oncology notes that with several screening options now available, the new recommendations emphasize the patient-provider shared decision-making process for informed choice on the most suitable screening method for the individual. Although the new recommendations are important, there needs to be a continued effort to ensure all women are screened adequately since there is a significant number of U.S. women who remain unscreened, the statement affirms. It also calls for all women to have access to all tests, with appropriate coverage by insurance companies.

"We hope the USPSTF recommendations foster more discussions between patients and providers about cervical cancer screening, promote opportunities for patient education on the benefits and safety of HPV vaccination for cervical cancer prevention and encourage providers to offer HPV vaccines in their offices," the statement says.[3]

The new recommendation indicates that more research needs to be done to determine if different strategies for cervical cancer screening could help reduce the number of deaths from the disease. Continued scientific efforts are necessary for better follow-up with the currently available screening methods as well, and to make sure screening access and treatment are available across different populations, it affirms.

"We know that some populations are affected by cervical cancer more than others," says the task force vice chair **Douglas Owens**, MD, MS, Henry J. Kaiser, Jr. Professor, and director of the Center for Health Policy in the Freeman Spogli Institute for International Studies and of the Center for Primary Care and Outcomes Research in the Department of Medicine and School of Medicine at Stanford University. "We need more research to determine how we can effectively reduce disparities among these women, and ultimately help save more lives."

The new guidance creates an "exciting possibility" of self-administered HPV specimen collection, says **Anita Nelson**, MD, professor and chair of the obstetrics and gynecology department at Western University of Health Sciences in Pomona, CA. Although

EXECUTIVE SUMMARY

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- For women 30 to 65 years of age, the new guidance calls for screening with the Pap test every three years or with the high-risk human papillomavirus (hrHPV) test alone or with both tests every five years.
- The new guidance applies to women with a cervix who do not have any signs or symptoms of cervical cancer.

such a move may make it easier for women with poor access to healthcare to be tested at home, it may have significant economic effects on clinicians.

"Such a change will certainly require extensive education to reassure women we are not abandoning them and track women over time to remind them of a once-every-five-year test," says Nelson. "With the mobility of women geographically and their need to switch healthcare systems periodically, that may not be possible."

Evaluate the Evidence

In issuing its current guidance, the task force ordered an examination of the scientific evidence regarding cervical cancer screening to provide updated recommendations.[4] The review included results from studies that compared screening with hrHPV testing alone or cotesting to screening with just cervical cytology. The review did not cover information about the accuracy of the tests or the effectiveness of cytology for cervical cancer screening, since these issues were covered in the 2012 review.[5] The current review also did not focus on data regarding women < 21 years of age or those with removal of the uterus and cervix. However, the review confirmed that there was no change in the evidence since the 2012 review.

Compared to cytology, testing for high-risk HPV types identified a higher rate of precancerous changes, according to the review. In addition, higher false-positive results and follow-up tests were associated with the hrHPV tests than with cytology.[4]

The review demonstrates that there is "strong evidence for the effectiveness of high-risk HPV testing used alone as a cervical cancer screening test," noted **Joy Melnikow**, MD, MPH, director of the Center for Healthcare Policy and Research and professor of family and community medicine at the University of California, Davis. Melnikow served as lead author for the evidence review.

"We found that regular screening with any method will lead to lower cervical cancer rates," said Melnikow in a press statement. "In the U.S., where most women are not part of an organized screening program, our biggest challenge is reaching women who have not been screened." ■

REFERENCES

1. US Preventive Services Task Force, Curry SJ, Krist AH, et al. Screening for cervical cancer: US Preventive Services Task Force recommendation statement. *JAMA* 2018;320:674-686.
2. Learman LA, Garcia FAR. Screening for cervical cancer: New tools and new opportunities. *JAMA* 2018;320:647-649.
3. American College of Obstetricians and Gynecologists, American Society for Colposcopy and Cervical Pathology, Society of Gynecologic Oncology. Leading women's health care groups issue joint statement on USPSTF final cervical cancer screening recommendations. Aug. 21, 2018. Available at: https://bit.ly/2PI8GJQ. Accessed Sept. 20, 2018.
4. Melnikow J, Henderson JT, Burda BU, et al. Screening for cervical cancer with high-risk human papillomavirus testing: Updated evidence report and systematic review for the US Preventive Services Task Force. *JAMA* 2018;320:687-705.
5. Vesco KK, Whitlock EP, Eder M, et al. Screening for Cervical Cancer: A Systematic Evidence Review for the US Preventive Services Task Force: Evidence Synthesis No. 86. Rockville, MD: Agency for Healthcare Research and Quality; 2011.

Barriers Still Exist for Teen Access to Emergency Contraception

Even though age limits for purchasing emergency contraception (EC) were removed five years ago, results of a recent survey of more than 700 Texas pharmacies found that 46.5% of drugstores still have an age restriction for buying the medication, and more than 50% require a consultation before medication purchase.[1]

Texas ranks fifth among states with the highest rates of teen pregnancy, and the state's rate of repeat teen pregnancy is the highest in the United States, says paper co-author **Maria Monge**, MD, assistant professor at Dell Medical School and Texas A&M College of Medicine and director of adolescent medicine at Dell Children's Medical Center of Central Texas. However, not all teenagers across Texas have easy access to comprehensive sex education and contraception services, leading many teens to substitute for more effective contraceptive methods, she notes.

"As Texas faces ongoing challenges in improving maternal health outcomes and decreasing teen pregnancy rates, removing barriers so that adolescents may more easily access over-the-counter emergency contraception is an important piece of this puzzle that deserves additional attention," noted Monge in a press statement.

Understand Barriers to Access

Barriers to emergency contraception and disparities in access still exist for adolescents, according to the results of a 2017 study. The study involved female mystery callers who posed as 17-year-old teenagers who were seeking emergency contraception. Using standardized scripts, the callers contacted 979 pharmacies in Nashville, Philadelphia, Cleveland, Austin, and Portland.[2] Data indicate that 8.3% of the pharmacies reported that emergency contraception could not be obtained under any circumstances. That figure is not significantly different from a similar survey performed in 2012.[3]

"Given the history of EC in the U.S. and all the changing regulations, the fact that misinformation exists isn't shocking; however, it is disappointing because the point of removing all the restrictions (which occurred in 2013) was to help decrease this misinformation and improve access," says **Tracey Wilkinson**, MD, MPH, assistant professor of pediatrics at Indiana University in Indianapolis, who conducted an initial investigation of pharmacy access published in 2012. "Our study shows that there are still persistent barriers for adolescents, and so there is still work to be done to assure that everyone (especially adolescents) can have guaranteed access to EC when it is needed."

In 2017, members of the American Society for Emergency Contraception, a nonprofit advocacy group, visited retail pharmacies nationwide to determine whether EC was stocked on store shelves as allowed by Food and Drug Administration regulations. Members also checked prices, as well as whether outdated age restrictions were being imposed.

In 40% of stores, researchers found that EC was not stocked on the shelf. Independent pharmacies were more likely than chain stores (91% vs. 24%) to keep the medication behind the counter, rather than to stock it on the shelf. Almost one-third (30%) of stores were continuing to impose age restrictions and identification requirements for EC sales, despite removal of such barriers.

EXECUTIVE SUMMARY

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- A 2017 national survey of retail pharmacies found that almost one-third (30%) of stores were continuing to impose age restrictions and identification requirements for EC sales, despite removal of such barriers.
- Educate adolescent patients on the efficacy of various forms of emergency contraception. The copper intrauterine device represents the most effective option for EC.

The time has come for all pharmacies to "do the right thing" and stock emergency contraception on the shelf, where it belongs, says **Kelly Cleland**, MPA, MPH, the society's executive director. The society is calling on all pharmacies, whether independent or part of a chain, to stock the medication on the shelf and eliminate unnecessary identification checks, since there is no longer an age restriction on the sale of EC, Cleland stated in a press release.

Give Teens the Facts

Providers can help educate adolescent patients on the efficacy of various forms of emergency contraception. The copper intrauterine device (IUD) represents the most effective emergency contraception method, with a 0.09% failure rate after placement.[4] Ulipristal acetate and mifepristone are oral forms of emergency contraception that are most effective, with failure rates that range from 0.9% to 2.1%.[5]

Although levonorgestrel EC pills are less effective than ulipristal acetate and mifepristone, they are available over the counter. Failure rates for levonorgestrel pills range from 0.6% to 3.1%. No matter what form of emergency contraception is preferred, all methods of emergency contraception should be used as soon as possible after unprotected intercourse.[6]

"There are two approaches to emergency contraception that are both much more effective than Plan B One Step: one is insertion of the Copper T380A IUD and the second is what is used in much of Europe, mifepristone," observes **Robert Hatcher**, MD, MPH, professor emeritus of gynecology and obstetrics at Emory University School of Medicine in Atlanta. "Today, any community has multiple sources of the Copper T 380A IUD."

A 2017 Committee Opinion from the American College of Obstetricians and Gynecologists calls for the following practices when it comes to emergency contraception:

• Counsel patients that the most effective type of emergency contraception is a copper IUD. Obstetrician-gynecologists and other healthcare providers should think about including the copper IUD emergency contraception in their practices and providing the IUDs on the same day.

"OUR STUDY SHOWS THAT THERE ARE STILL PERSISTENT BARRIERS FOR ADOLESCENTS."

• When possible, prescribe ulipristal acetate for EC. Ulipristal acetate is more effective than levonorgestrel in preventing pregnancy after unprotected intercourse at all time points within 120 hours. It is also effective for women of all body sizes.

• Provide prescriptions for emergency contraception, especially ulipristal acetate, in advance to help prevent barriers to immediate EC access.

• Use a visit for emergency contraception as an opportunity to give patients information about various contraception methods and to start the patient with a regular method, when possible.[7] ■

REFERENCES

1. Monge M, Loh M, Goff C, et al. Barriers to obtaining and effectively using emergency contraception in Texas adolescents. Presented at the Pediatric Adolescent Societies 2018 Meeting. Toronto; May 2018.
2. Wilkinson TA, Clark P, Rafie S, et al. Access to emergency contraception after removal of age restrictions. *Pediatrics* 2017;140: doi: 10.1542/peds.2016-4262.
3. Wilkinson TA, Fahey N, Suther E, et al. Access to emergency contraception for adolescents. *JAMA* 2012;307: 362-363.
4. Cleland K, Zhu H, Goldstuck N, et al. The efficacy of intrauterine devices for emergency contraception: A systematic review of 35 years of experience. *Hum Reprod* 2012; 27:1994-2000.
5. International Consortium for Emergency Contraception (ICEC). *Emergency Contraceptive Pills: Medical and Service Delivery Guidelines*. 3rd edition. New York; 2012.
6. Society for Adolescent Health and Medicine. Emergency contraception for adolescents and young adults: Guidance for health care professionals. *J Adolesc Health* 2016;58:245-248.
7. Committee on Health Care for Underserved Women. Committee Opinion No 707: Access to emergency contraception. *Obstet Gynecol* 2017;130:e48-e52.

More Teens Are Up to Date on HPV Shot

Good news — just-released data indicate human papillomavirus (HPV) vaccination completion in U.S. adolescents has gone up by five percentage points from 2016 to 2017, and initiation of the vaccine has increased 5.1 percentage points, on average, each year since 2013. According to the statistics, about two-thirds of teens ages 13-17 received the initial HPV vaccine dose, and about half of teens received the complete set of recommended doses.[1]

"This vaccine is the best way to protect our youth from developing cancers caused by HPV infection," says **Robert Redfield**, MD, director of the Centers for Disease Control and Prevention (CDC). "Vaccination is the key to cervical cancer elimination."

CDC researchers compiled data from the NIS-Teen annual survey, which estimates adolescent vaccination coverage in the 50 U.S. states, the District of Columbia, selected local areas, and territories. The telephone survey is conducted with parents and guardians of eligible adolescents.

Although more teens are receiving the HPV shot, public health officials say there is room for improvement. A little more than half (51%) have not received the full series of injections, data indicate. Location plays an important role; results indicate that fewer teens in rural areas are getting the HPV shot compared to adolescents in urban areas. Statistics suggest that among rural teens, the rate of those who received the initial HPV vaccine dose was 11 percentage points lower than among teens in urban areas.[1]

"While we understand it can be a challenge for some clinicians in rural areas to stock all recommended vaccines, these clinicians can still play a critical role in their patients' health and protect them from serious diseases by referring them to other vaccine providers," notes **Nancy Messonnier**, MD, director of the National Center for Immunization and Respiratory Diseases at the CDC.

Use Lags Behind Other Vaccines

Researchers note that HPV vaccination initiation lags behind coverage with quadrivalent meningococcal conjugate vaccine (MenACWY) and tetanus and reduced diphtheria toxoids and acellular pertussis vaccine (Tdap). It is routinely recommended that children ages 11-12 receive two doses of the vaccine.

Public health officials are working to improve the number of teens who receive the vaccine on schedule. Officials are implementing a new measure of adolescent vaccines, known as the combined Healthcare Effectiveness Data and Information Set, that evaluates whether adolescents have received all three vaccines, including the HPV vaccine, that are recommended for completion by age 13.[2]

Are Shots Making Impact?

Has the HPV vaccine made an impact since the first shot formulation was approved in the United States in 2006? Because it takes many years for HPV infection to advance to invasive cancer, measuring the shot's impact on cervical cancer may take decades. Looking for early indicators of the vaccine's effect, public health officials now are monitoring the incidence of high-grade cervical lesions that could progress to invasive cancer if left untreated. Through the CDC's HPV Impact Monitoring Project, researchers are looking at the incidence of cervical lesions among women age 18 and older in five different communities in California, Connecticut, New York, Oregon, and Tennessee.

Demographic and clinical information from laboratory and medical records is being collected in these areas on every woman who has a high-grade cervical lesion; for women ages 18-39 who have a high-grade cervical lesion, additional information such as insurance, cervical cancer

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screening history, and vaccination history is recorded. In addition, archived tissue specimens are obtained and sent to CDC for HPV type testing for 37 HPV types, including those targeted by HPV vaccines.

According to one study conducted from 2008 to 2012, among women who received at least one HPV vaccine dose, the prevalence of HPV 16/18 in cervical squamous intraepithelial neoplasia 2 (CIN2+) lesions decreased from 53.6% to 28.4%. There was no significant statistical difference among unvaccinated women or those with unknown vaccination status.[3]

Information from national surveys suggests a reduction in the prevalence of HPV vaccine type in young women in the first four years of the HPV vaccine program. There was a reduction of 56% in HPV vaccine types in the cervical-vaginal samples from teens ages 14-19.[4] Decreases among women ages 20-24 were seen within six years of vaccination introduction.[5] Among teens 14-19, there was a 71% reduction in prevalence of HPV vaccine type after eight years.[5] In women ages 20-24, there was a 61% reduction.[6] ■

REFERENCES

1. Walker TY, Elam-Evans LD, Yankey D, et al. National, regional, state, and selected local area vaccination coverage among adolescents aged 13-17 years — United States, 2017. *MWR Morb Mortal Wkly Rep* 2018;67:909-917.
2. National Committee for Quality Assurance. NCQA updates quality measures for HEDIS 2018. Washington, DC: National Committee for Quality Assurance; 2018.
3. Hariri S, Bennett NM, Niccolai LM, et al; HPV-IMPACT Working Group. Reduction in HPV 16/18-associated high grade cervical lesions following HPV vaccine introduction in the United States — 2008-2012. *Vaccine* 2015;33:1608-1613.
4. Markowitz LE, Hariri S, Lin C, et al. Reduction in human papillomavirus (HPV) prevalence among young women following HPV vaccine introduction in the United States, National Health and Nutrition Examination Surveys, 2003-2010. *J Infect Dis* 2013;208:385-393.
5. Markowitz LE, Liu G, Hariri S, et al. Prevalence of HPV after introduction of the vaccination program in the United States. *Pediatrics* 2016;137:e20151968.
6. Oliver S, Unge, ER, Lewis R, et al. Prevalence of human papillomavirus among females after vaccine introduction — National Health and Nutrition Examination Survey, United States, 2003-2014. *J Infect Dis* 2017;216:594-603.

Safety Warning Issued for Fluoroquinolone Antibiotics

Check your clinical practice when it comes to treatment of uncomplicated urinary tract infections (UTIs) — the federal Food and Drug Administration (FDA) now is asking clinicians to consider other treatment options besides fluoroquinolone antibiotics because of risks associated with their use.[1] The action comes with labeling changes warning of the potential risk of hypoglycemic coma and certain adverse mental health effects, such as problems with attention and memory, disorientation, agitation, nervousness, and delirium, associated with use of the drugs.

Examples of fluoroquinolones approved by the FDA are levofloxacin, ciprofloxacin, ciprofloxacin extended-release tablets, moxifloxacin, ofloxacin, gemifloxacin, and delafloxacin. The regulatory agency issued a previous safety communication in 2016 concerning oral and injectable fluoroquinolone antibiotics and the risk of adverse effects to tendons, muscles, and joints, as well as to nerves and the central nervous system that can occur together in the same patient. Such side effects may be permanent and can happen hours to weeks after exposure to fluoroquinolone medications, the FDA noted.

In its latest communication, the FDA has determined that for patients with acute bacterial sinusitis, acute exacerbation of chronic bronchitis, and uncomplicated UTIs, clinicians should reserve fluoroquinolone use for patients who do not have other options for treatment. In cases of serious bacterial infections, such as anthrax, plague, and bacterial pneumonia, the benefits of using fluoroquinolone antibiotics outweigh the medication risks, making them an appropriate therapeutic option.

"The use of fluoroquinolones has a place in the treatment of serious bacterial infections — such as certain types of bacterial pneumonia — where the benefits of these drugs outweigh the risks, and they should remain available as a therapeutic option," said **Edward Cox**, MD, director of the Office of

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- The action comes with labeling changes warning of the potential risk of hypoglycemic coma and certain adverse mental health effects, such as problems with attention and memory, disorientation, agitation, nervousness, and delirium, associated with use of the drugs.
- For acute bacterial sinusitis, acute exacerbation of chronic bronchitis, and uncomplicated urinary tract infections, clinicians should reserve the use of fluoroquinolones for patients without other options for treatment.

Antimicrobial Products in the FDA's Center for Drug Evaluation and Research, in a press statement. "The FDA remains committed to keeping the risk information about these products current and comprehensive to ensure that health care providers and patients consider the risks and benefits of fluoroquinolones and make an informed decision about their use."

What to Use for UTIs?

Clinicians are very familiar with UTIs. About 62.7 million adults 20 years of age and older have reported having at least one UTI — and 81% of them were women.[2] Asymptomatic bacteriuria is more prevalent among women than men. Approximately 5-6% of young women who are sexually active and not pregnant experience asymptomatic bacteriuria, compared to less than 0.1% of young men who do.[3]

Most cases of UTI are caused by an infection that travels from the urethra to the bladder. Urethral massage, sexual intercourse, or mechanical instrumentation can allow bacteria to move up the urethra, with colonization and infection occurring in the bladder. Uropathogenic *Escherichia coli* causes approximately 80-90% of UTIs.[4] *Staphylococcus saprophyticus* often is the cause of UTIs in the lower urinary tract. The bacteria have been found in about 3% of sexually active, reproductive-age, nonpregnant women with pyelonephritis.[5]

Women with acute bacterial cystitis typically present with symptoms such as difficult or painful urination and urinary frequency or urgency because of irritation of the mucosa in the urethra and bladder. They also may report suprapubic pain or pressure. Using a clean-voided midstream urine sample, a reading of 100,000 single isolate bacteria per milliliter has been considered an indicator of significant bacteriuria. This provides good specificity, but a 50% sensitivity.[6] Decreasing the colony count to 1,000-10,000 bacteria per milliliter in patients who are symptomatic can improve sensitivity without significantly compromising the specificity.

According to guidance from the Centers for Disease Control and Prevention, nitrofurantoin, trimethoprim-sulfamethoxazole (TMP-SMX, in areas where local resistance is less than 20%), and fosfomycin are appropriate first-line agents to treat acute uncomplicated cystitis in healthy, adult, nonpregnant, premenopausal women. Fluoroquinolones, such as ciprofloxacin, should be saved for situations in which other agents are not appropriate.[7] The current recommended treatment for uncomplicated acute bacterial cystitis in women is a three-day antimicrobial regimen.[8] ■

REFERENCES

1. U.S. Food and Drug Administration. FDA Drug Safety Communication: FDA reinforces safety information about serious low blood sugar levels and mental health side effects with fluoroquinolone antibiotics; requires label changes. Silver Spring, MD: FDA; 2018. Available at: https://bit.ly/2NhWx0v. Accessed Sept. 19, 2018.
2. Griebling TL. Urinary tract infection in women. In: National Institute of Diabetes and Digestive and

Kidney Diseases. *Urologic Diseases in America*. NIH Publication No. 07-5512. Washington, DC: U.S. Government Printing Office; 2007: 587-619.
3. Hooton TM, Stamm WE. The vaginal flora and urinary tract infections. In: Mobley HL, Warren JW. *Urinary Tract Infections: Molecular Pathogenesis and Clinical Management*. Washington, DC: American Society for Microbiology Press; 1996: 67-94.
4. Ronald A. The etiology of urinary tract infection: Traditional and emerging pathogens. *Am J Med* 2002;113 (Suppl 1A):14S-19S.
5. Scholes D, Hooton TM, Roberts PL, et al. Risk factors associated with acute pyelonephritis in healthy women. *Ann Intern Med* 2005;142:20-27.
6. Fihn SD. Clinical practice. Acute uncomplicated urinary tract infection in women. *N Engl J Med* 2003;349:259-266.
7. Centers for Disease Control and Prevention. Antibiotic Prescribing and Use in Doctor's Office. Available at: https://bit.ly/2Q5oYNK. Accessed Sept. 19, 2018.
8. American College of Obstetricians and Gynecologists. ACOG Practice Bulletin No. 91: Treatment of urinary tract infections in nonpregnant women. *Obstet Gynecol* 2008;111: 785-794.

WASHINGTON WATCH

Conservatives Work to Bar Private Coverage of Abortion

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The future of the U.S. healthcare system is one of the key issues in the November 2018 elections. Depending on the outcome, the results could provide congressional conservatives and President Trump new opportunities to undermine or eliminate the Affordable Care Act (ACA), or grant new power to congressional progressives seeking to build on the ACA and further expand U.S. health coverage. Congress also may pursue compromise measures to tamp down rising insurance premiums, and could be forced to address the fallout from continued efforts to overturn the ACA in the courts. One common barrier to each of those goals will be anti-abortion conservatives' long-standing campaign to eliminate private insurance coverage of abortion.[1]

Anti-abortion policymakers often have pursued this goal directly at the state level. Eleven states have abortion coverage bans on all state-regulated insurance plans, and many others bar coverage in specific markets.[2] By contrast, at the federal level, abortion foes have used federal funding as their main lever against abortion coverage. They have succeeded when it comes to Medicaid: For more than four decades, the Hyde Amendment has barred federal funding for abortion coverage under Medicaid, except in cases of life endangerment, rape, or incest.

The ACA provided anti-abortion policymakers an opportunity to expand those restrictions to private insurance because the law included substantial new federal subsidies to help people afford insurance premiums and cost-sharing. In an attempt to meet the demands of anti-abortion lawmakers, the ACA segregates federal dollars from private dollars to ensure that no federal money pays for abortion coverage or services. However, the anti-abortion movement falsely argues that this policy allows for "indirect" funding of abortion, and has fought relentlessly for a more radical policy: to bar any health insurance plan that receives any amount of federal money from covering abortion.

This demand has been a primary objective for many conservatives throughout the Trump presidency. Every attempt by House and Senate Republican leaders to "repeal and replace" the ACA in 2017 included multiple abortion coverage restrictions along these lines. For example, the American Health Care Act, which passed the House in May 2017, would have barred abortion coverage in any individual or small employer plan receiving federal premium subsidies, and would have attached a similar restriction to a new block grant that states could use to stabilize their insurance markets, such as through direct payments to insurance companies or additional subsidies to individuals or employers buying

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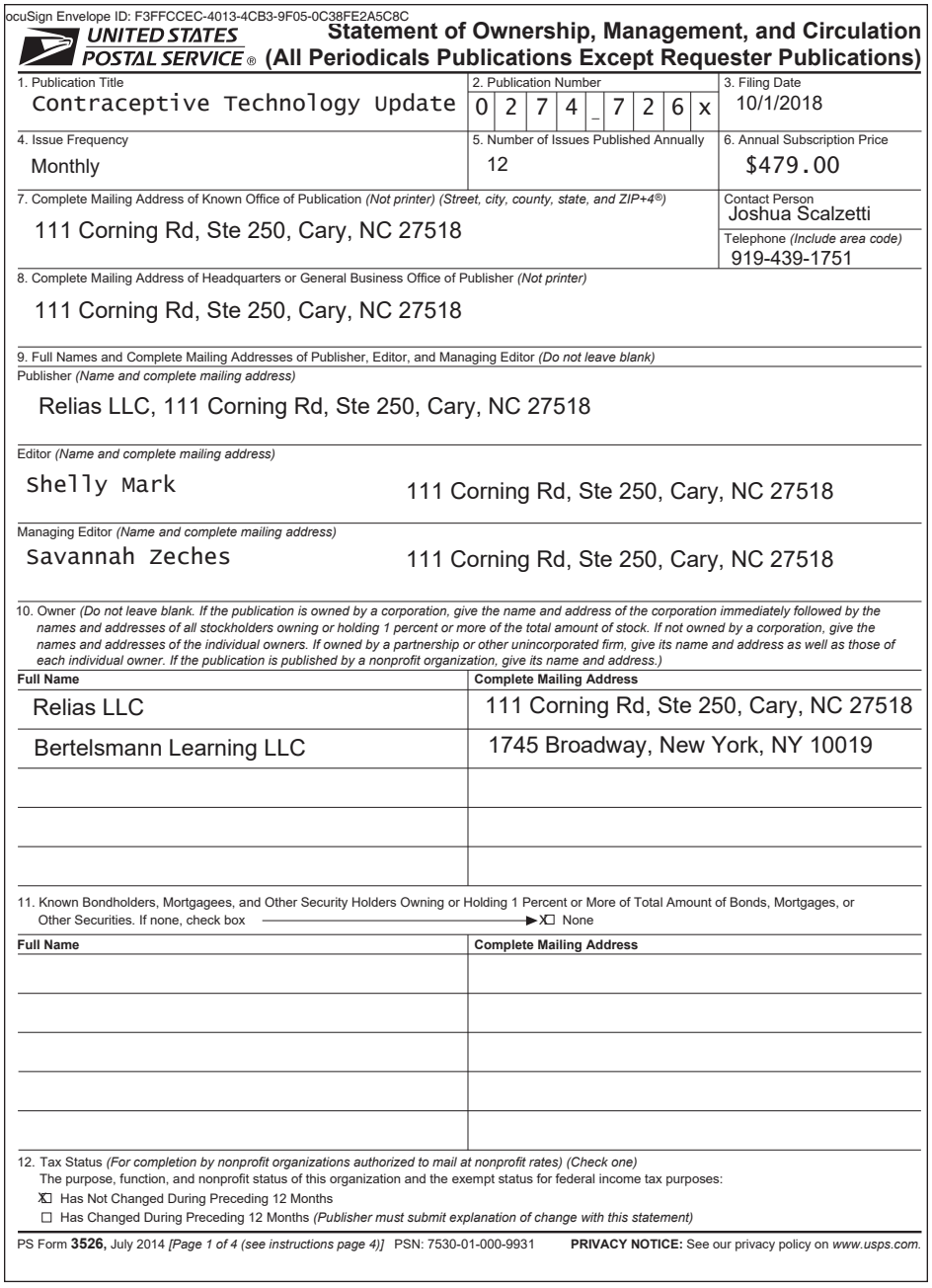
coverage.[3] The September 2017 proposal by Sens. Lindsey Graham (R-SC) and Bill Cassidy (R-LA) included similar restrictions as part of its much larger block grant and as part of its proposed expansion to the use of Health Savings Accounts.[4]

Anti-abortion politics also have helped to stop multiple bipartisan attempts to address rising insurance premiums. For example, in March 2018, proposals to offer new federal money for reinsurance (which would protect insurance plans against unexpected costs and thereby lower premiums) and to restore federal payments to insurers to offset cost-sharing reductions for low-income consumers (which President Trump terminated last fall, sparking substantial premium hikes) were derailed in part by anti-abortion lawmakers' insistence on attaching abortion coverage bans.[5] Supporters of abortion rights argued that doing so would effectively eliminate abortion coverage in ACA marketplace plans entirely and in any private insurance plan receiving reinsurance dollars.



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New Federal Restrictions Would Hurt Women

Even without new federal restrictions, private coverage of abortion is already endangered by state-level restrictions and the ACA's burdensome requirements to segregate funding. Even when abortion coverage is permitted, it often is unavailable.[6,7] Yet, new coverage restrictions would do additional harm to availability. They also would endanger coverage in the four states — California, New York, Oregon, and Washington — that require state-regulated private insurance plans to cover abortion. A federal restriction could force those states either to stop enforcing their requirements or to lose billions in federal insurance subsidies.

Whether health insurance covers abortion has real-world financial implications for patients. An abortion typically costs around $500 at 10 weeks' gestation, and considerably more later in pregnancy.[8] That can be simply unaffordable without insurance: About one-third of lower income people say they would be unable to pay for an unexpected $500 medical bill, and another third would have to borrow money.[9]

Patients without abortion coverage report delaying payments for utility bills, rent, food, and other necessities to pay for the abortion procedure and related costs.[10] Moreover, the time spent scraping together funds for an abortion can lead to delays in obtaining care, which can make it harder to find a provider and lead to increased costs and further delays.

In other cases, lack of abortion coverage can lead to an unwanted birth, with all the consequences that come with it. Most abortion patients say they cannot afford a child or another child, and that having a baby would interfere

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with their work, school, or ability to care for their other children.[11] ■

REFERENCES

1. Sonfield A. Restrictions on private insurance coverage of abortion: A danger to abortion access and better U.S. health coverage. *Guttmacher Policy Review* 2018;21:29-34.
2. Guttmacher Institute. Restricting insurance coverage of abortion. Sept. 1, 2018. Available at: https://bit.ly/2c2NBpH. Accessed Sept. 17, 2018.
3. Sonfield A. Conservatives are using the American Health Care Act to restrict private insurance from covering abortion. *Health Affairs Blog* March 21, 2017. Available at: https://bit.ly/2Ml19OX. Accessed Sept. 17, 2018.
4. Sonfield A. Graham-Cassidy continues efforts to bar private insurance coverage of abortion. *Health Affairs Blog* Sept. 25, 2017. Available at: https://bit.ly/2x4uBDP. Accessed Sept. 17, 2018.
5. Kliff S. Republicans' new plan to fix Obamacare, explained. *Vox,* March 19, 2018. Available at: https://bit.ly/2N2iyku. Accessed Sept. 17, 2018.
6. Hasstedt K. Abortion coverage under the Affordable Care Act: Advancing transparency, ensuring choice and facilitating access. *Guttmacher Policy Review* 2015;18:14-20.
7. Salganicoff A, Sobel L, Kurani N, Gomez I. Coverage for abortion services in Medicaid, Marketplace plans and private plans. Menlo Park, CA: Kaiser Family Foundation. Jan. 20, 2016.
8. Jerman J, Jones RK. Secondary measures of access to abortion services in the United States, 2011 and 2012: Gestational age limits, cost, and harassment. *Women's Health Issues* 2014;24:e419-424.
9. DiJulio B, Kirzinger A, Wu B, Brodie M. Data note: Americans' challenges with health care costs. Available at: https://www.kff.org/health-costs/poll-finding/data-note-americans-challenges-with-health-care-costs/. Accessed Sept. 17, 2018.
10. Jones RK, Upadhyay UD, Weitz TA. At what cost? Payment for abortion care by U.S. women. *Women's Health Issues* 2013;23:e173-178.
11. Finer LB, Frohwirth LF, Dauphinee LA, et al. Reasons U.S. women have abortions: Quantitative and qualitative perspectives. *Perspect Sex Reprod Health* 2005;37:110-118.

CONTRACEPTIVE TECHNOLOGY UPDATE®

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CME/CE QUESTIONS

1. **The 2018 recommendations from the US Preventive Services Task Force call for women ages 21 to 29 to be tested in what manner?**

   a. Every three years with cervical cytology
   b. Every three years with hrHPV screening
   c. Every four years with cotesting
   d. Every five years with cervical cytology

2. **What is the range of failure rates for levonorgestrel emergency contraceptive pills?**

   a. 0.09% to 1.0%
   b. From 0.6% to 3.1%
   c. 0.09% to 2.1%
   d. 1.0% to 2.9%

3. **Which of the following is *not* a Food and Drug and Administration-approved fluoroquinolone?**

   a. Levofloxacin
   b. Ciprofloxacin
   c. Moxifloxacin
   d. Trovafloxacin

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.