Planned Parenthood® of Northern New England

Senator Carney, Representative Moonen and members of the Joint Standing Committee on the Judiciary, my name is Nicole Clegg, I serve as the Interim CEO at Planned Parenthood of Northern New England and I am here today to submit testimony in opposition to LDs 494, 771, 1197, 1249 and 1614.

Planned Parenthood of Northern New England provides comprehensive reproductive and sexual health care to more than 14,000 people in Maine at four health centers located in Biddeford, Portland, Sanford and Topsham. People turn to us for affordable, high-quality care including wellness exams, birth control, disease testing and treatment, cancer screenings, abortion care as well as a variety of primary care services. We see everyone who comes to us regardless of ability to pay, and in a typical year, we provide more than $4 million in free and discounted care to our communities in Maine.

As a mission driven health care provider, we fundamentally believe everyone should be able to get affordable, high quality sexual and reproductive health care in their communities, no matter where they live or how much money they make and we advocate for policies that help make this vision a reality.

LD 494

In 2019, the Maine Legislature passed LD 820, removing barriers to decision-making about a pregnancy in both public and private insurance. This legislation was designed to ensure that all Mainers regardless of their ability to pay could make personal, medical decisions about abortion. Since then, the legislature has been clear, the decisions about a pregnancy are best left to the person and their medical provider. The government's role is to protect this right and not restrict or interfere with it.

Denying insurance coverage for abortion, especially for those people with the lowest incomes, directly impacts someone's ability to make their own decisions about a pregnancy. When it comes to the most important decisions in life, such as whether to become a parent, it is vital that people are able to consider all the options available to them, regardless of insurance or income. It's not the place of the state to decide for someone else whether they can get an abortion. Yet when the state elects to cover only one option, continuation of a pregnancy. and deny coverage for abortion, that's exactly what is happening. The right to make these decisions personally, privately, in the interest of one's health is taken away.

By requiring coverage of legal abortion for public insurance, LD 820 removed a significant barrier to exercising the rights Maine lawmakers have said are fundamental to a person's ability to self-determine. Maine joined fourteen other states comprising more than half the country's Medicaid insured population, in providing full coverage of pregnancy care including abortion.

Due to racism and systemic barriers to access, people of color and other marginalized populations face greater disparities in access to and utilization of health care, and often fare worse than white people on measures of health status and health outcomes.[1] Women of color in the United States already have less access to healthy food, safe housing, and basic health care due to the intersections of structural racism, inequality, sexism, classism, xenophobia, and other systemic barriers.[2] It comes as no surprise then that people of color are disproportionately impacted by barriers to care like the Hyde Amendment. Expanded access to abortion services is critical for this group of people, as the abortion rate among women of color has not gone down as dramatically as the overall abortion rate for all groups of women.[3]

If the Maine law providing abortion coverage for people insured by MaineCare were to be repealed the consequences would be swift and severe. Maine's poorest would be forced to pay out-of-pocket for a sudden expensive medical emergency. Those insured by MaineCare are more likely to bear the hardship of transportation costs, childcare, loss of pay as well as struggle to reach one of three nonprofit abortion providers in the state. People in Maine routinely travel several hours one way to access care and stripping them of their health coverage could essentially strip them of their ability to make their own decision about a pregnancy.

This hardship is amplified by the fact that **one in four Medicaid-qualified women who seek an abortion is forced to carry her pregnancy to term because of cost.**[4] Women who are forced to carry an unwanted pregnancy to term are three times more likely to fall into poverty within two years. Many more are forced to delay their procedure for as long as two to three weeks while they raise money, with the costs and risks of the procedure increasing the longer they wait.

Research has also found that denying women access to abortion when she has determined it is the right decision is not only tied to poverty, but it also leads to greater risks of complications in pregnancy and poorer health outcomes. It also is connected to violence as women become tethered to abusive partners.

Poor people face significant disparities when it comes to reproductive health. Compared with higher-income women, poor women's rates of unintended pregnancy and abortion are each five times as high, and their unplanned birth rate is six times as high. These disparities are rooted in deeply entrenched inequities in the areas of health-insurance coverage, health care, and medically accurate sex education, as well as other health-promoting resources. When the

---

[1] Samantha Artiga *et al.,* "Key Facts on Health and Health Care by Race and Ethnicity," Kaiser Family Foundation (June 7, 2016), available at https://www.kff.org/disparities-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity/.

[2] Treuhaft, Sarah & Karpyn, Allison, "The Grocery Gap: Who Has Access to Healthy Food and Why It Matters," PolicyLink & The Food Trust (2010), available at http://thefoodtrust.org/uploads/media_items/grocerygap.original.pdf.

[3] *Id.* at "Abortion is a Common Experience for U.S. Women."

[4] https://www.ansirh.org/research/turnaway-study#results

Maine Legislature made the important decision to include abortion coverage for people insured by MaineCare, people's lives were changed as they were able to make the best decisions for themselves, their futures, and their families. Their reproductive autonomy became a reality rather than a right only truly attainable by those most able to afford it.

LD 771

LD 771 proposes rewriting Maine's current abortion law adding language about the withdrawal of consent by the patient to the procedure. While informed consent is the cornerstone of both medical ethics and reproductive autonomy, we have deep concerns that this bill is written with the intent of stigmatizing abortion both legally by inserting language around the withdrawal of consent not seen in other informed consent statutes and by requiring the usage of the term "until the death of the fetus" as point at which the ability to withdraw informed consent ends. Furthermore, we fear that by inserting language allowing for the withdrawal consent "until the fetus has died" this bill may be giving credence to the medically inaccurate and dangerous concept of "abortion reversal."

There is no evidence, no clinical trials, and no credible data to support so-call medication abortion "reversal." Rather, a study to test the protocol had to be halted early due to patient safety concerns. Researchers concluded that patients in early pregnancy who follow the suggested protocol are at risk of significant hemorrhage. The concept is universally rejected by the country's medical experts including the American Medical Association, which stated that policies like these "contradict reality and science" and the American Congress of Obstetricians and Gynecologists (ACOG) states that "claims of medication abortion reversal are not supported by the body of scientific evidence, and this approach is not recommended in ACOG's clinical guidance on medication abortion."

The entire concept of the so-called abortion reversal was imagined by Dr. George Delgado, a family medicine physician in San Diego who identifies as pro-life. In 2012, he announced that he had developed a method to reverse a medication abortion. He claimed that if patients changed their minds about the abortion after taking mifepristone, he could administer progesterone and they could continue the pregnancy. He published a letter in which he claimed that through this treatment four of six patients were able to continue their pregnancies. When his research came to the attention of anti-abortion advocates, states around the country started passing laws requiring doctors to tell patients that medication abortions could be reversed. To be clear, his claims did not meet the rigorous standards for medical research but opponents to abortion wasted no time pushing this dangerous practice, resulting in eight states, to date, that have passed harmful legislation perpetuating the myths that so-called abortion reversal is a safe option for people. People's health and safety should be safeguarded by policymakers not reckless cast aside to advance an agenda based solely on interfering in people's personal decisions about pregnancy.

LD 1197

As with LD 771, LD 1197 is grounded in misinformation around abortion. In this case the bill purports to address the issue of "coerced abortion" but does so in a stigmatizing manner– singling out one procedure in statute. This legislation appears to be based on the presumption that a patient electing to have an abortion cannot have fully considered their decision and thus must be given additional information to be truly "informed." This bill is unnecessary as Maine's current informed consent statutes on abortion, both for minors and for adults already explicitly require that providers account for the possibility of coercion.

As reproductive health care providers, Planned Parenthood clinicians are trained to assess patients for the possibility of reproductive coercion and other forms of intimate partner violence (IPV). Indeed, as other testimony heard today details, Maine's abortion providers are a key resource in supporting partners escape dangerous relationships. This bill's focus on abortion is misguided. While coerced abortion is an example of reproductive coercion, it is an incredibly rare (with studies showing that reproductive coercion preventing access to abortion is twice as likely as coercion pushing a partner to end a pregnancy), especially in comparison to other forms of coercion such as birth control sabotage and forced pregnancy. LD 1197 in its attempt to place additional scrutiny on one medical procedure without applying similar scrutiny to other medical procedures such as prenatal care or well woman exams effectively stigmatizes abortion in the law altering statutes because of misconceptions or misplaced concerns around abortion, abortion providers and patients.

LD 1249

LD 1249 seeks to ban both the use of telehealth for the purposes of medication abortion and the shipment of pills. Medication abortion has a long, well-established track record of safety and a blanket restriction on the transport of medication abortion pills could effectively bar these medications essentially the regimen in the state of Maine.

Proponents of this bill argue that it is a necessary measure to protect the safety of the women of Maine, this could not be further from the truth. Medication abortion prescribed and partially administered in a health center or via consultation with a provider in the comfort of the patient's own home is an incredibly safe procedure with a very low complication rate.

At Planned Parenthood, when a patient has been determined to be eligible for and elects to have a medication abortion, they'll meet with a nurse or a doctor, either in person at the health center, or in the case of telehealth by video or phone, to go over the procedure.

Since its FDA approval in 2000, medication abortion has been safely used by millions of patients and now accounts for well over half of all abortions performed in the United States. The overall safety of the regimen is not in doubt, medication abortion has a complication rate far below that of many common medical procedures with one study placing the serious complication rate at 0.31%[5], less than one fourth the complication rate of pregnancy. Medication

[5] Upadhyay, Ushma; Desai, Sheila; Zlidar, Vera; Weitz, Tracy; Grossman, Daniel; Anderson, Patricia; Taylor, Diana, "Incidence of Emergency Department Visits and Complications After Abortion",

abortion via telehealth has a similarly high safety record, with studies showing the complication rate for telehealth abortion to be similar or even lower than that for abortion in a health center.[6] Given these results, the American College of Obstetricians and Gynecologists has recommended the utilization of telehealth for medication abortion since 2015 and the FDA moved to allow for the same in early 2021.

Medication abortion is critically important to maintaining abortion access in rural states like our own. While Maine currently has abortion providers in 88% of counties encompassing 84% of Maine women of reproductive age; those numbers would drop to as low as 19% of counties and 46% of women if LD 1249 were to become law.

LD 1249 would seriously restrict access to care. As with many of the restrictions proposed today, the impact of this bill would fall disproportionately on already marginalized populations. Even before *Roe* was overturned, economic inequality was a key factor in determining who had access to abortion care and information. In addition to the cost of an abortion itself, individuals seeking abortion care also face indirect expenses, such as travel, unpaid time off work, and child and family care. Because the regimen can be prescribed remotely and safely taken in the privacy and convenience of one's own home, it can help reduce the costs associated with transportation or child and family care, as well as allowing for more flexible scheduling. Banning medication abortion via telehealth and potentially forcing patients to receive in-clinic abortion care would create significant additional burdens that could delay or even deny access to care altogether.

LD 1614

At its core LD 1614 is aimed at perpetuating a deep distrust of the judgment and decision-making of the pregnant people by policymakers and in doing so endangers their health and well-being. It removes the ability of a patient to make their own decisions, undermines the trusting relationship between provider and patients and forces the patient to navigate a 48-hour waiting period, causing delays in the delivery of care. As a sexual and reproductive health care provider, Planned Parenthood wants everyone to have the information and support they need to make decisions about their pregnancy. That's why we provide patients with counseling, support, and information about their options including parenting, adoption, and abortion if that's what the patient wants. Every person should be able to trust that their health care provider can provide them with the most appropriate care based on their individual needs. Medical professionals and patients, working together, are the best judges for which procedures and tests are medically necessary.

Obstetrics & Gynecology, 125(1):p 175-183, January 2015. https://journals.lww.com/greenjournal/Fulltext/2015/01000/Incidence_of_Emergency_Department_Visits_and.29.aspx

[6] Daniel Grossman, Daniel; Grindlay, Kate, "Safety of Medical Abortion Provided Through Telemedicine Compared With In Person", *Obstetrics & Gynecology*,130(4):778-782, October 2017. https://pubmed.ncbi.nlm.nih.gov/28885427/

Substituting the judgment of patients and medical professionals with a one size fits all government mandate can have dire consequences. Research consistently finds that state-imposed waiting periods do not lead to a reduction in the number of abortions but instead cause increases in costs associated with accessing care and further delays resulting in an increase of the number of abortions occurring later in pregnancy, which carry with them increased health risks.[7] One study on the impact of a 48 hour waiting period found that patients did not benefit from the additional time instead there was a marked increase in abortions occurring in the second trimester, nearly 40 percent.[8] Another found that waiting periods could effectively prevent a patient from accessing medication abortion entirely by delaying access to care beyond which that option is available.[9] These types of burdensome and unnecessary delays are felt most acutely by those people who are already disproportionately impacted by systemic barriers to quality health care - people of color, people in rural communities, and people struggling financially.[10] The reason for this is simple: waiting periods compound existing difficulties in accessing care from having to travel far distances, take multiple days off from work, arrangements for child care as nearly 60% of people seeking access to abortion are already parents and other barriers people must navigate to access care.

While progress has been made over the years to expand access to abortion in Maine, there are still limitations and scheduling challenges people encounter. Mandating two appointments multiple days apart which would mean people seeking care would have to arrange for double the childcare, double the travel arrangements, and double the time off work all of which become exponentially more difficult for anyone seeking access to care outside of the immediate vicinities of these providers service areas.

The bottom line is that proposals like LD 1614 are deeply unpopular because they don't reflect our values. We want people to have access, support, and access to high quality care. Mandated counseling, forced ultrasounds and waiting periods are harmful and an unwarranted intrusion in the patient-provider relationship. We already know what the real consequences are of these proposals. We just must look at states with these barriers to understand that they do not alter people's decision-making, but they do cause delays and increases in abortions later in pregnancy.[11] These policies do not improve patient health or safety rather they increase the risks. This proposal along with the others you have heard today are designed to shame and

---

[7] Rachel K. Jones, Jenna Jerman; "Time to Appointment and Delays in Accessing Care Among U.S. Abortion Patients" *Guttmacher Institue* (2016), https://www.guttmacher.org/report/delays-in-accessing-care-among-us-abortion-patients

[8] Jason M. Lindo, Mayra Pineda-Torres; "New Evidence on the Effects of Mandatory Waiting Periods for Abortion" *National Bureau of Economic Research* (2019), https://www.scribd.com/document/430919278/MandatoryWaitingPeriods-LindoPinedaTorres

[9] Sarah Roberts, David Turok, Elise Belusa, Sarah Combellick, Ushma Upadhyay, "Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women" *Perspectives on Sexual and Reproductive Health* (2016), https://onlinelibrary.wiley.com/doi/abs/10.1363/48e8216

[10] Kari White, Victoria deMartelly, Daniel Grossman , Janet Turan; "Experiences Accessing Abortion Care in Alabama among Women Traveling for Services" *Womens Health Issues*. (2016), https://www.whijournal.com/article/S1049-3867(16)00004-9/fulltext

[11] https://www.guttmacher.org/evidence-you-can-use/waiting-periods-abortion

judge people who need an abortion and are part of a broader strategy to push abortion out of reach entirely

Conclusion

Despite the polarizing rhetoric you may have heard this week, voters are in large agreement about abortion care.[12] When asked what the experience should be like for a woman who has decided to have an abortion, the overwhelming majority want women to be supported by loved ones (88%) and treated with dignity (86%). Voters don't want women forced to walk through protestors (83%), nor do they want women to face additional burdens in accessing care (81%). Only a slim minority (25%) want women to experience pressure to change their minds and an even smaller group (15%) want women to have to encounter additional burdens like waiting periods.[13] Two-thirds of voters say it should be covered by her insurance. More than 8 in 10 say that care should be affordable, available in her community and without delays.[14]

Collectively, the bills heard today would take away those rights and I urge you to consider the consequences of the proposals considered this morning would mean for persons who may become pregnant in Maine. In the wake of the Supreme Court's radical decision in *Dobbs,* it is more important than ever that Maine stand up for the rights of people who may become pregnant. Please vote ought not to pass on LDs 494, 771, 1197, 1249 and 1614. Thank you.

---

[12] Only 16% of Maine voters want to see abortion made illegal. https://www.plannedparenthoodaction.org/pressroom/new-survey-finds-majority-of-voters-in-maine-alaska-do-not-want-to-see-roe-v-wade-overturned

[13] https://view.publitas.com/perryundem-research-communication/perryundem-report-on-public-opinion-toward-abortion/page/22

[14] https://view.publitas.com/perryundem-research-communication/perryundem-report-on-public-opinion-toward-abortion/page/22