Testimony of Maine Public Health Association in Opposition to:
LD 253: An Act to Prevent the MaineCare Program from Covering Abortion Services
LD 682: An Act to Amend Certain Laws Regarding Abortions
LD 886: An Act to Regulate Medication Abortions
LD 887: An Act to Make Manufacturers Responsible for Proper Disposal of Abortion Drugs and Require a Health Care Provider to Be Physically Present During a Chemical Abortion
LD 975: An Act to Repeal Laws Allowing Abortion and to Criminalize Abortion
LD 1007: An Act to Update the State's Informed Consent Laws Regarding Drug-induced Abortion

Joint Standing Committee on Judiciary
Room 438, State House
Friday, March 28, 2025

Good morning, Senator Carney, Representative Kuhn, and distinguished members of the Joint Standing Committee on Judiciary. My name is Rebecca Boulos. I am a resident of South Portland and executive director of Maine Public Health Association.

MPHA is the state's oldest, largest, and most diverse association for public health professionals. We represent more than 850 individual members and 70 organizations across the state. The mission of MPHA is to advance the health of all people and places in Maine. As a statewide nonprofit association, we advocate, act, and advise on critical public health challenges. We are not tied to a national agenda, which means we are responsive to the needs of Maine's communities, and we take that responsibility seriously.

MPHA opposes LD 253: "An Act to Prevent the MaineCare Program from Covering Abortion Services," LD 682: "An Act to Amend Certain Laws Regarding Abortions," LD 886: "An Act to Regulate Medication Abortions," LD 887: "An Act to Make Manufacturers Responsible for Proper Disposal of Abortion Drugs and Require a Health Care Provider to Be Physically Present During a Chemical Abortion," LD 975: "An Act to Repeal Laws Allowing Abortion and to Criminalize Abortion," and LD 1007: "An Act to Update the State's Informed Consent Laws Regarding Drug-induced Abortion." Ultimately, these bills restrict access to safe reproductive health care, which is a direct denial that health care is a human right and that people who are pregnant are autonomous and free in making decisions about their own health and health care.

Denying people who are pregnant access to safe, timely, and affordable abortion care harms their physical, mental, and social well-being in ways that ripple throughout their lives. Longstanding systems of health and economic inequity – including access to reproductive health care – cause continued and documented disparities in educational achievement, financial security, and social status.[1] Access to safe abortion services is an essential component of comprehensive reproductive health care; lack of access disproportionately impacts individuals living in rural areas, racial and ethnic minorities, adolescents, incarcerated people, and people with low income.

In Maine, nearly half of all pregnancies are unintended (with a greater percentage among low-income people); of those, approximately 28% end in induced abortions.[2] Denying people the right to access safe abortion services makes it more likely they will suffer complications and increases the likelihood of dying. In states with more restrictive abortion care access policies, there is a 7% higher maternal mortality rate; in states with restrictions on Medicaid coverage of abortion care, there is a 29% higher maternal mortality rate, compared to states with less restrictive policies.[3]

Forcing someone who is pregnant to carry a high-risk pregnancy to term threatens the life – and quality of life – of the mother and the fetus. For many life-threatening cases, abortion is standard care. Indeed, the wellbeing of people who are pregnant extends beyond the physical state of their pregnancy. It relates to their psychosocial wellbeing, economic security (including employment and housing security), privacy, safety from abuse and discrimination, and recognition of personal autonomy and freedom for making decisions about the factors that influence their health. When people who are pregnant can't access safe abortion services, they seek them elsewhere, increasing the risk of harm. Conversely, forcing full-term pregnancies when that is not what the person wants, or is safely able to do, strains other community resources, including childcare, education, health care, and social support and services.

We all want just and fair opportunities to achieve good health and the freedom to make our own choices. In the context of reproductive health care, actions that reduce disparities include education about sexuality and health, access to affordable and quality prenatal and postpartum care, paid parental leave and childcare, wage parity, increased preventive measures and support systems for people living in physically, emotionally, and economically abusive situations, and access to safe, timely, affordable, and respectful abortion care. This slate of bills would do the opposite.

We believe these bills are harmful to public health, and we respectfully request the committee to vote LDs 253, 682, 886, 887, 975, and 1007 "Ought Not to Pass." Thank you for considering our testimony.

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[1] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); 2017 Jan 11. 3, The Root Causes of Health Inequity.

[2] Kost K. 2015. Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002. New York: Guttmacher Institute.

[3] Vilda D, Wallace ME, Daniel C, Goldin Evans M, Stoecker C, and Theall KP. 2021. State Abortion Policies and Maternal Death in the United States, 2015–2018. *American Journal of Public Health*, 111:1696-1704.