maine family planning

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Testimony in support as amended:
LD 2203, "An Act to Require Health Insurance Coverage for Federally Approved Nonprescription Contraceptives"
Joint Standing Committee on Health Coverage, Insurance, and Financial Services
February 20, 2024

Senator Bailey, Representative Perry, and honorable members of the Joint Standing Committee on Health Coverage, Insurance, and Financial Services, my name is Laura Harper, I'm a Senior Associate at Moose Ridge Associates and I live in Hallowell. I am testifying on behalf of Maine Family Planning (MFP) in support of LD 2203 as amended.

MFP provides comprehensive sexual and reproductive health care to adults and teens through telehealth and at 18 health centers statewide. For more than 50 years, MFP has also served as the non-profit administrator of Maine's statewide family planning network, which includes 62 providers, encompassing federally qualified health centers (FQHCs), school-based health centers, as well as four Planned Parenthood clinics in Southern Maine. Altogether, Maine's sexual and reproductive health care network consists of 61 individual sites, stretching from Calais, to Fort Kent and all the way down to Sanford.

When it comes to contraception including methods, efficacy, access, and barriers, no one has been on the frontlines longer than MFP. That's why we are overjoyed by Representative Arford's amendment to broaden the insurance coverage proposed in her original bill. Reducing barriers to contraception improves all people's ability to control their reproductive lives, and we are excited to see even more legislators get involved in the work to increase access. Last session we worked with Representative Cluchey and Senator Brakey on his bill, LD 351, to increase access to hormonal methods. Thanks to this committee's leadership, Maine pharmacists who choose to, can offer to prescribe and administer hormonal contraception to Mainers at the pharmacy. What LD 2203 does is continue the work you all began in 2023; examine the existing challenges to family planning access and address them in a forward thinking manner. How can our laws solve not only today's problems but inoculate against future inconsistencies? Not only that, but be flexible for innovations in contraception?

This is the approach taken in the amendment before you today. As the FDA approves additional contraceptive methods safe for use without a prescription, it is in the best interest of not only our patients but all Maine health care consumers that access be as affordable and free of barriers as possible. Ask any of the insurance carriers behind me how much it costs to cover a pregnancy, delivery, and then the health care of a child. And then compare that to contraceptive coverage.

The timeliness of this bill was inspired by Opill, the first oral hormonal contraceptive to be FDA approved for use without a prescription. We are only months away from this groundbreaking medication being available on store shelves in Maine. What we predict will come next are additional options in oral hormonal contraception as well as other hormonal methods like the patch and the vaginal ring. At MFP we strive to work with our patients to find the right method for every individual. No one is the same. And lives change, circumstances change and our preferred contraception needs to be able to adapt. Insurance coverage should never be a barrier to meeting this deeply personal and intimate need.

So now I get to the scary news. Maybe you've read about this already but believe it or not, we're seeing a dramatic rise in congenital syphilis in the United States. According to the U.S. CDC just in the past decade, cases rose by 10-fold. And, 9 out of 10 cases could have been prevented with timely testing and treatment. Tragically in almost 40% of cases, pregnant people received no prenatal care. As a Title X grantee, MFP is being urged to meet this public health emergency head on. Indeed, Maine had its first case of congenital syphilis last year. According to their most recent bulletin, "For many sexually active people, the most significant risk factor for syphilis is living in a county with high rates of syphilis." Piscataquis, Oxford and York Counties all have high enough rates that they meet the threshold for the CDC's recommendation that all sexually active people between the ages of 15 and 44 be tested.

Opill will not protect you from syphilis. No hormonal contraceptive will. LD 2203 as amended is timely for another reason with syphilis on the rise; it includes insurance coverage for *all* FDA approved contraceptive methods including condoms. Besides abstinence, condoms are your best protection from syphilis as well as many other sexually transmitted infections (STIs). I'll repeat again, it is not only in the best interest of our patients, but all Maine health care consumers, that access to condoms, as well every method of contraception be affordable and free of barriers. Ask the carriers behind me how much it costs to treat congenital syphilis compared to contraceptive coverage.

I've described an urgent public health issue this amendment will help address. LD 2203 is also about health equity. It makes economic sense. It builds upon the legacy of this committee begun with LD 351. It prepares Maine for Opill and other nonprescription contraception in the future. Bottomline: it's the right thing to do.

I urge you to vote "ought to pass as amended." I'm happy to try and answer any questions. Thank you.

U.S. FOOD & DRUG ADMINISTRATION

www.fda.gov/birthcontrol

BIRTH CONTROL GUIDE

This birth control chart provides high-level information about different birth control options. It is meant for educational purposes for the general public. This chart is not meant to be a complete list of all available birth control options. Talk to your healthcare provider about the best birth control choice for you. If you do not want to get pregnant, there are many birth control options to choose from. No one product is best for everyone. Some methods are more effective than others at preventing pregnancy. Check the pregnancy rates on this chart to get an idea of how effective a method is at preventing pregnancy. The pregnancy rates tell you the number of pregnancies expected per 100 women during the first year of typical use. Typical use shows how effective the different methods are during actual use (including sometimes using a method in a way that is not correct or not consistent). The only sure way to avoid pregnancy is not to have sex.

Most Effective ↑ ↓ Least Effective

Methods	Number of pregnancies expected (per 100 women)*	Use	Some Risks or Side Effects* This chart does not list all of the risks and side effects for each product.
 Sterilization Surgery for Women	less than 1	Onetime procedure. Permanent.	Pain Bleeding Infection or other complications after surgery
 Sterilization Surgery for Men	less than 1	Onetime procedure. Permanent.	Pain Bleeding Infection
 IUD Copper	less than 1	Inserted by a healthcare provider. Lasts up to 10 years.	Cramps Heavier, longer periods Spotting between periods
 IUD with Progestin	less than 1	Inserted by a healthcare provider. Lasts up to 3-5 years, depending on the type.	Irregular bleeding No periods (amenorrhea) Abdominal/pelvic pain
 Implantable Rod	less than 1	Inserted by a healthcare provider. Lasts up to 3 years.	Menstrual Changes; Mood swings or depressed mood Weight gain; Headache Acne
 Shot/Injection	6	Need a shot every 3 months.	Loss of bone density Irregular bleeding/bleeding between periods Headaches; Weight gain Nervousness; Dizziness Abdominal discomfort
 Oral Contraceptives "The Pill" (Combined Pill)	9	Must swallow a pill every day.	Spotting/bleeding between periods Nausea Breast tenderness Headache
 Oral Contraceptives "The Pill" (Extended Continuous Use Combined Pill)	9	Must swallow a pill every day.	Spotting/bleeding between periods Nausea Breast tenderness Headache
 Oral Contraceptives "The Mini Pill" (Progestin Only)	9	Must swallow a pill at the same time every day.	Spotting/bleeding between periods Nausea Breast tenderness Headache
 Patch	9	Put on a new patch each week for 3 weeks (21 total days). Don't put on a patch during the fourth week.	Spotting/bleeding between menstrual periods Nausea; Stomach pain Breast tenderness; Headache Skin irritation
 Vaginal Contraceptive Ring	9	Put the ring into the vagina yourself. Keep the ring in your vagina for 3 weeks and then take it out for one week.	Vaginal discharge, discomfort in the vagina, mild irritation Headache; Mood changes Nausea; Breast tenderness
 Diaphragm with Spermicide	12	Must use every time you have sex.	Irritation Allergic reactions Urinary tract infection
 Sponge with Spermicide	12-24	Must use every time you have sex.	Irritation
 Cervical Cap with Spermicide	17-23	Must use every time you have sex.	Irritation Allergic reactions Abnormal Pap test
 Male Condom	18	Must use every time you have sex. Provides protection against some STDs.	Irritation Allergic reactions
 Female Condom	21	Must use every time you have sex. Provides protection against some STDs.	Discomfort or pain during insertion or sex Burning sensation, rash or itching
 Spermicide Alone	28	Must use every time you have sex.	Irritation Allergic reactions Urinary tract infection

OTHER CONTRACEPTION

Emergency Contraceptives (EC): May be used if you did not use birth control or if your regular birth control fails (such as a condom breaks). It should not be used as a regular form of birth control. Emergency contraception prevents about 55 - 85% of predicted pregnancies.

 Levonorgestrel 1.5 mg (1 pill) Levonorgestrel .75 mg (2 pills)	7 out of every 8 women who would have gotten pregnant will not become pregnant after taking this EC.	Swallow the pills as soon as possible within 3 days after having unprotected sex.	Menstrual changes; Lower stomach (abdominal) pain Headache; Nausea Dizziness; Vomiting Breast pain; Tiredness
 Ulipristal Acetate	6 or 7 out of every 10 women who would have gotten pregnant will not become pregnant after taking this EC.	Swallow the pills within 5 days after having unprotected sex.	Headache; Nausea Abdominal pain; Menstrual pain Tiredness; Dizziness

*For more information on the chance of getting pregnant while using a method or on the risks of a specific product, please check the product label or Trussell, J. (2011). "Contraceptive failure in the United States." Contraception 83(5):397-404.