Planned Parenthood® of Northern New England

Senator Carney, Representative Kuhn, and esteemed members of the Joint Standing Committee on the Judiciary, my name is Lisa Margulies, I serve as Vice President of Public Affairs, Maine, for Planned Parenthood of Northern New England, and I am here today to submit testimony in opposition to LDs 253, 682, 886, 887, 975, 1007, and 1154.

Planned Parenthood of Northern New England provides comprehensive reproductive and sexual health care in approximately 10,000 visits per year in Maine at four health centers located in Biddeford, Portland, Sanford, and Topsham, as well as online via telehealth. People turn to us for affordable, high-quality care including wellness exams, birth control, disease testing and treatment, cancer screenings, behavioral health care, abortion care, gender-affirming care, in addition to a variety of primary care services.

As a mission driven health care provider, we fundamentally believe everyone should be able to access 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. All people deserve to access comprehensive reproductive health care, including abortion and gender-affirming care, free from shame, stigma, and intimidation. We see everyone who comes to us regardless of ability to pay, and in a typical year, we provide more than $1.2 million in free and discounted care to our communities in Maine. For many, we are their only access to the health care system.

When the Supreme Court overturned *Roe v. Wade*, it removed federal protections for abortion access and put hundreds of millions of Americans' abilities to access the health care of their choice at the whims of politicians in their respective states. Since that decision, abortion access in the United States has devolved into a chaotic and often confusing labyrinth where one's ability to access health care is determined by their address and state legislature. In the midst of this national storm, Maine has remained a safe harbor for those seeking access to vitally needed sexual and reproductive health care.

While some states, like Maine, have taken steps to protect and expand access to abortion, 19 others have moved to restrict or even outright ban access to this safe, often medically necessary health care procedure. The result has been a national health care crisis. In states with abortion bans, pregnant people have suffered from serious and life-threatening health conditions and even died due to lack of treatment, infant mortality rates have increased, and much needed clinicians have left in significant numbers. Research has shown that those denied abortions are not only more likely to face worse health outcomes, but also more likely to be unable to afford basic expenses, more likely to face unemployment, and more likely to be living in poverty alongside their children.[i] These restrictions harm patients and their families and also threaten the stability of our health care infrastructure and economy, with one recent study finding that abortion bans cost the United States economy $61 billion annually and resulted in lower state GDPs in several states.[ii]

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In this tumultuous national landscape, we are grateful that Maine lawmakers have acted to protect, preserve, and expand access to abortion in our state. Abortion is health care that is critical to the health, safety, and wellbeing of our patients and all Maine people. Access to abortion is essential to protect Mainers' autonomy, agency, and dignity. Politicians are unqualified to make deeply personal, private, complex decisions for patients about their reproductive health care. Instead, every person should have the right to make health care decisions in consultation with their health care providers.

Protecting abortion rights is not only central to Maine values, but also extremely popular. The majority of Americans, 61%, believe their state should allow abortion for any reason,[iii] and 65% of Mainers believing that it should be legal in all or most cases.[iv] These bills are dangerous for Maine people and depart from our core values along with the will of Maine people.

LD 253

In 2019, the Maine Legislature passed LD 820, removing barriers to abortion for patients with both public and private insurance. This legislation was designed to ensure that all Mainers could make personal, private medical decisions regardless of their income level. By requiring MaineCare coverage of abortion, LD 820 removed significant barriers to health care for people with low incomes.

Repealing LD 820 would create a health care crisis in our state, greatly impacting our most vulnerable populations. Put simply, it would prevent or hinder pregnant people from accessing abortion care due to expense, at great harm to them and their families. In fact, research has found that pregnant people who are forced to carry an unwanted pregnancy to term are three times more likely to face unemployment, four times more likely to be living in poverty, and more likely to maintain contact with a partner who is violent.[v] Access to abortion makes people safer, more stable, and more prosperous, and thereby makes our state safer, more stable, and more prosperous.

LD 682

LD 682 would repeal LD 1619, passed in 2023, which amended the state's Reproductive Privacy Act in three areas: abortion data collection, the criminalization of abortion, and the administration of abortion later in pregnancy.

Abortion Data Collection

Previously, the state used the US Standard Report of Induced Termination of Pregnancy published by the National Center for Health Statistics for data collection and reporting for abortions provided in Maine. The form had not been updated in decades. LD 1619 repealed the use of this form and implemented a data collection procedure similar to the one already in place for miscarriage data. This change was needed because form was outdated and forced providers to collect irrelevant and deeply stigmatizing information from patients on topics like education level and marital status during

...ments. In addition, data collected could have posed risks to patient and clinician safety ...ed by hostile parties, a particularly acute risk for patients travelling from states with abortion ... These risks are no longer abstract: since the fall of *Roe*, we have seen states in which abortion ...are is banned attempt to reach into states where it remains legal and access medical records and penalize or even prosecute patients and providers.[vi]

Criminalization of Abortion

LD 1619 decriminalized abortion later in pregnancy (previously illegal unless the health or life of the pregnant person were at risk) as well as obtaining medication abortion outside of the medical system. The prior law caused a chilling effect on providers unwilling to risk potential criminal prosecution for providing necessary care. The law also segregated and thereby stigmatized abortion from other legal medical procedures by singling it out as a potential crime. Criminalizing abortion runs counter to Maine values and the will of Maine people to keep this medical procedure legal and accessible.

Abortion Later in Pregnancy

Prior to being updated in 2023, the Reproductive Privacy Act restricted abortion at "viability." This ambiguous term left providers unclear and sometimes unable to navigate or accept the risks to providing needed care to their patients. Estimations of viability are imprecise and can be inaccurate by up to four weeks. LD 682 reinstitutes pre-2023 language with the addition of an exception for "lethal fetal anomaly."

Abortion later in pregnancy occurs for two primary reasons: 1) new information, generally about fetal or maternal health; 2) barriers to care and/pr structural, personal, or economic reasons which have prevented the pregnant person from accessing care at an earlier date. While abortions at or after twenty-one weeks account for 1% of all abortions performed in the United States, they are and will continue to be a necessary part of comprehensive pregnancy care.[vii] The national fallout from the *Dobbs* decision has shown that "medical necessity" exceptions to abortion restrictions are largely unworkable; in practice, these exceptions function as abortion bans at worst and unnecessary roadblocks to the provision of care at best.[viii]

LDs 886, 887, 1007

These bills are grouped together because they all seek to regulate and restrict access to medication abortion. Medication abortion is safe, effective, and has been used by more than five million people in the United States for abortion and miscarriage care since the FDA approved it more than 20 years ago. It is safer than many commonly prescribed medications including Viagra and penicillin, and its complication rate is far below many common medical procedures. One study placed the serious complication rate of medication abortion at 0.31%, less than one fourth the complication rate of

pregnancy.[ix] Medication abortion has helped ensure that patients are able to make their own private medical decisions and has expanded access to reproductive health care.

"Abortion Reversal" Misinformation

LD 886 and 1007 require patients be given details about chemical agents, drugs, or means by which the procedure may be reversed, so-called "abortion reversal." This is patent misinformation. There are no evidence, clinical trials, or credible data to support so-called medication abortion "reversal." In fact, a study to test an "abortion reversal" protocol had to be halted early due to patient safety concerns.[x] In that study, researchers warned that patients in early pregnancy who follow the suggested "reversal" protocol were at high risk of serious hemorrhage.

"Abortion reversal" is also universally rejected by the country's medical experts including the American Medical Association, which stated that messages about "abortion reversal" procedures "contradict reality and science,"[xi] and the American Congress of Obstetricians and Gynecologists (ACOG), which state that "[c]laims 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."[xii]

Requirement of In-Person Exam and Administration of Medication

The imposition of an in-person requirement for the examination of the patient as well as the administration of medications per LDs 886 and 887 are medically unnecessary barriers to care that, as with many other efforts to restrict access to abortion, are supposedly being pursued to protect patients. The facts do not bear this out.

Medication abortion via telehealth is extremely safe and effective, with studies showing the complication rate for telehealth abortion to be similar or even lower than that for abortion in a health center.[xiii] Given these results, the ACOG has for at least a decade endorsed the use of telehealth for medication abortion,[xiv] and the FDA moved to allow for the same in 2021.[xv]

As with many of the restrictions proposed by these bills, the impact of imposing in-person visit requirements for medication abortion 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 medication abortion 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 care and enable more flexible scheduling. Effectively banning medication abortion via telehealth and forcing patients to receive in-clinic abortion care would create significant additional burdens to receiving treatment.

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Medication Abortion in the Water (LD 887)

LD 887 uses faulty science in an attempt to restrict access to medication abortion. Any claims that the pills used in medication abortion will migrate into wastewater and impact that environment are ungrounded and specious.

There is no evidence that medication abortion harms humans, the environment, or animals via our water. The question anti-abortion activists are asking now has been asked and answered decades ago: experts at the FDA found mifepristone is safe for the environment. Results from an environmental assessment in 1996 found the drug to have "no effect" on test organisms and that mifepristone could be used and disposed of without adverse effects on the environment or endangered or threatened species.[xvi] The EPA has examined thousands of water samples over the last 10 years and found extremely low traces of drugs in our wastewater. The EPA has expertly concluded that there is no impact from even the combined impact of all drugs–much less an impact from one comparatively very rare medication.

This conspiracy is based on anti-abortion ideology, not science. Studies allegedly supporting this theory have poor methodology or are twisted to fit an anti-abortion narrative. For example, Students for Life cited a 2018 study for their claim that mifepristone harms aquatic life, but the study only tested for traces of mifepristone in wastewater or surface water and not the drug's impact on aquatic life.[xvii]

This conspiracy is an anti-abortion attack on drugs essential to reproductive health care, intending to scare people and make abortion pills sound dangerous when decades of evidence has proven they are not. Holding manufacturers of medication abortion liable for traces of "endocrine-disrupting chemicals" from medication abortion found in water is an attack on medication abortion, hormonal contraceptives, and gender-affirming hormone therapy, and could be used to harass drug manufacturers with costly politically motivated litigation.

LD 975

LD 975 not only repeals the laws authorizing abortion in Maine and criminalizes abortion care, but also offers an alternative definition for the beginning of life. LD 975 defines the beginning of life as the point of conception, effectively granting legal rights to fetuses and embryos.

Put simply, LD 975 poses a severe danger to the health and welfare of people of Maine, for all the reasons described in this testimony. It is worth noting that abortion bans have led to the deaths of pregnant people as well as higher rates of infant deaths, especially among black infants.[xviii]

The Turnaway Study examined the impact of being denied access to a desired abortion on roughly 1,000 women over 5 years from states across the country, including Maine. The largest study of its

kind to date, its findings were stark. People denied abortions who were forced to carry unwanted pregnancies to term were found to be:

- Four times more likely to be living below the Federal Poverty Level
- More likely to experience life-threatening complications from pregnancy such as eclampsia and death
- More likely to stay connected to partners who are abusive
- More likely to have poor physical health for years, with conditions like chronic pain and gestational hypertension
- Less likely to have aspirational plans for their life

The study also found serious detrimental consequences for children, including both those born of an unwanted pregnancy and existing children.[xix]

Moreover, granting legal rights to fetuses and embryos could have far-reaching consequences: even greater regulation of pregnant people in addition to restrictions or bans on some forms widely accessed sexual and reproductive health care such as IVF and even some forms of contraception. This is no longer hypothetical–defining life as beginning at conception is a driving factor in efforts in many states' efforts to restrict access to Emergency Contraception (EC).[xx] It was also central to the Alabama Supreme Court's 2024 ruling that embryos created through IVF were considered children, throwing the state into uncertainty about the legality of IVF.[xxi]

It is also important to note that abortion bans and restrictions have the potential to destroy our fragile health care infrastructure here in Maine. States that have imposed abortion bans or restrictions are seeing "an exodus of women's health providers" while new clinicians are choosing not to practice in such states due to restrictions in the care they may provide.[xxii] Any loss of providers would be devastating in light of Maine's current health care landscape: thirteen of our sixteen counties have health provider shortages.[xxiii] Every provider, including Planned Parenthood of Northern New England, is struggling with staffing shortages and the costs to rehire and train staff, stagnant reimbursement rates from insurance companies, and inflation. The COVID-19 pandemic only exacerbated these issues. As we have seen here in Maine with several recent hospital mergers and closures of labor and delivery units, it is difficult and more expensive to operate in rural areas.

LD 1154

LD 1154 seeks to restrict access to abortion, substituting the judgement of policymakers for that of pregnant persons and their medical providers. This bill would amend the state's existing abortion-specific informed consent law to require additional counseling for people seeking abortion care after receiving a "lethal fetal anomaly" diagnosis, including a 24-hour waiting period to access care after state-mandated counseling and resource lists. This bill puts a thumb on the scale in favor of one decision over the other, requiring only those declining perinatal hospice care and seeking

abortion to certify in writing that they have received the state-mandated counseling and resource lists and have maintained their decision to seek abortion care. The bill also adds professional disciplinary action for a health care professional that violates the requirements of the entire informed consent law, as amended by this bill.

These requirements are stigmatizing and create barriers to care for those seeking abortion after a diagnosis of a fetal anomaly. It also implies that pregnant people are unsure of their decision to seek abortion care. Additionally, mandating a 24-hour waiting period for any abortion represents an unjust and potentially dangerous injection of arbitrary political judgment into the medical process. That said, the mandatory waiting period proposed by LD 1154 is a particularly cruel and potentially dangerous imposition on pregnant persons, applying only to those seeking the abortion of fetuses diagnosed with a lethal fetal anomaly.

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. We provide patients with counseling, support, and information about their options including parenting, adoption, and abortion if that is 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. This mandated state counseling requirement is unnecessary, because, under current law, there is nothing preventing providers from talking to patients about the availability of perinatal hospice care, and providers do typically give families receiving diagnoses information about their options.

Substituting the judgment of patients and medical professionals with a one-size-fits-all government mandate leads to dire consequences. 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 in the number of abortions occurring later in pregnancy, which carry with them increased health risks. One study on the impact of waiting periods found that patients did not benefit from the additional time and instead there was a marked increase in abortions occurring in the second trimester, nearly 40 percent.[xxiv] Another found that waiting periods may effectively prevent a patient from accessing medication abortion entirely by delaying access to care beyond when that option is available.[xxv]

Waiting periods and multiple visit requirements are harmful and unwarranted intrusions into the patient-provider relationship. 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.[xxvi] Waiting periods compound existing difficulties in accessing care including planning and costs related to travel, taking days off work, and childcare arrangements (the majority of people seeking abortion are already parents).

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Conclusion

Since the fall of *Roe*, Maine has led the country in ensuring that all people have access to comprehensive reproductive health care. Amid this national storm, thank you for ensuring that Maine remains a safe harbor for care and a beacon of hope for the rest of the country. Please vote ought not to pass on LDs 253, 682, 886, 887, 975, 1007, and 1154.

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