IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

PLANNED PARENTHOOD OF THE GREAT NORTHWEST,	)	
Plaintiff,	)	
v.	)	
WILLIAM J. STREUR, et al.,	)	
Defendants.	)	
	)	Case No. 3AN-14-04711 CI

DECISION AND ORDER

I. INTRODUCTION

In 1998, Alaska Medicaid terminated funding for most medically necessary abortions for low-income women. In 2001, an Alaska Supreme Court case held that this constituted differential treatment of pregnant women and so violated the equal protection clause of Alaska's constitution.[1] A recently enacted statute and regulation again eliminate funding for most medically necessary Medicaid abortions. Under the holding of the 2001 case, this too violates equal protection.

II. FACTS AND PROCEEDINGS

a) Background.

Many Alaskan women qualify for joint federal-state Medicaid, a program enacted to provide comprehensive medical services to low-income people. In 1998, Alaska's Department of Health and Social Services ("DHSS") enacted a

[1] *State, Dept. of Health & Social Services v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904 (Alaska 2001), interpreting Alaska Const. art. I, § 1.

regulation restricting state-funded Medicaid abortions to instances of rape, incest, or risk of death to the pregnant woman.[2] This standard matched the federal Medicaid funding standard termed the Hyde Amendment,[3] which precludes federal Medicaid expenditures for abortions except:

> (1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Plaintiff Planned Parenthood of Alaska, now Planned Parenthood of the Great Northwest (hereafter "Planned Parenthood" or "Plaintiff"), challenged the new state regulation. The superior court, Judge Sen Tan, held that the regulation violated a woman's right to reproductive freedom under the privacy clause of Alaska's constitution.[4] He subsequently issued an injunction ordering DHSS to fund "medically necessary" abortions. Judge Tan defined that term as follows:

> [T]he terms medically necessary abortions or therapeutic abortions are used interchangeably to refer to those abortions certified by a physician as necessary to prevent the death or disability of the woman, or to ameliorate a condition harmful to the woman's physical or psychological health, as determined by the treating physician performing the abortion services in his or her professional judgment.[5]

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[2] 7 AAC 43.140.
[3] The Hyde Amendment is re-enacted annually as an amendment to the appropriation bill funding the Federal Department of Health and Human Services, Department of Labor, and Department of Education.
[4] Memorandum and Decision (March 16, 1999), *Planned Parenthood of Alaska v. Perdue*, Case No. 3AN-98-07004CI, 1999 WL 34793393.
[5] Judge Tan Order (Sept. 18, 2000), (attached to Pl.'s Jan. 29, 2014 Memo Re Pl.'s Mot. for TRO and Prelim. Inj., Exhibit 3).

In *State, Dept. of Health & Social Services v. Planned Parenthood of Alaska, Inc.*[6] (hereafter "*State, DHSS*") the Alaska Supreme Court held that the DHSS counterpart to the Hyde Amendment's rape, incest or life-endangerment standard violated the Alaska Constitution's equal protection clause because it denied funding for medically necessary abortions while affording medically necessary services in non-abortion contexts:

> By providing health care to all poor Alaskans except women who need abortions, the challenged regulation violates the state constitutional guarantee of "equal rights, opportunities, and protection under the law." The State, having established a health care program for the poor, may not selectively deny necessary care to eligible women merely because the threat to their health arises from pregnancy. Because we decide this case on state constitutional equal protection grounds, we do not review the superior court's privacy-based ruling. We do note, however, that our analysis today closely parallels that applied by many of the fifteen courts that have rejected similar restrictions. Although other courts' decisions have rested on a variety of state constitutional provisions, including equal protection, constitutional equal-rights-for-women clauses, due process, and privacy, the underlying logic has been the same in decision after decision: "[W]hen state government seeks to act for the common benefit, protection, and security of the people in providing medical care for the poor, it has an obligation to do so in a neutral manner so as not to infringe upon the constitutional rights of our citizens." As the Massachusetts Supreme Judicial Court observed, the constitutional principle at issue is straightforward: "It is elementary that 'when a State decides to alleviate some of the hardships of poverty by providing medical care, the manner in which it dispenses benefits is subject to constitutional limitations.' " The State's spending discretion is limited by the constitution- "[w]hile the State retains wide latitude to decide the manner in which it will allocate benefits, it may not use criteria which discriminatorily burden the exercise of a fundamental right."[7]

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[6] *State, DHSS v. Planned Parenthood, supra* note 1.
[7] *Id.* at 908-909 (citations omitted).

The Court referenced Judge Tan's order in a footnote, acknowledging that the parties had briefed and argued his grant of injunctive relief.[8] But the Court stopped short of adopting Judge Tan's definition of "medical necessity" or otherwise explicitly defining the term. Nonetheless the Court gave examples of health conditions that qualified for funding under a constitutionally compliant medical necessity standard:

> The range of women whose access to medical care is restricted by the regulation is broad. According to medical evidence provided to the superior court, some women-particularly those who suffer from pre-existing health problems-face significant risks if they cannot obtain abortions. Women with diabetes risk kidney failure, blindness, and preeclampsia or eclampsia-conditions characterized by simultaneous convulsions and comas-when their disease is complicated by pregnancy. Women with renal disease may lose a kidney and face a lifetime of dialysis if they cannot obtain an abortion. And pregnancy in women with sickle cell anemia can accelerate the disease, leading to pneumonia, kidney infections, congestive heart failure, and pulmonary conditions such as embolus. Poor women who suffer from conditions such as epilepsy or bipolar disorder face a particularly brutal dilemma as a result of DHSS's regulation-medication needed by the women to control their own seizures or other symptoms can be highly dangerous to a developing fetus. Without funding for medically necessary abortions, pregnant women with these conditions must choose either to seriously endanger their own health by forgoing medication, or to ensure their own safety but endanger the developing fetus by continuing medication. Finally, without state funding, Medicaid-eligible women may reach an advanced stage of pregnancy before they can gather enough money for an abortion; resulting late-term abortions pose far greater health risks than earlier procedures.[9]

b) The current proceeding.

For years after *State, DHSS*, that agency funded Medicaid abortions

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[8] *Id.* at 907 n. 11.
[9] *Id.* at 907.

consistently with Judge Tan's injunctive order defining medical necessity. But during the administration of former governor Sean Parnell, the issue of Medicaid funding resurged. The governor vetoed legislation to increase the family income level for Medicaid eligibility for indigent women with children, from 150% to 200% of the federal poverty guidelines. The governor explained that his veto was necessary to preclude any increase in Medicaid-funded abortions.[10]

Subsequently DHSS commissioner William Streur drafted a regulation redefining medical necessity in the abortion context.[11] The regulation employed a standard developed by the office of state senator John Coghill, with the addition of a mental health provision. Contrary to normal procedure, the commissioner acted without DHSS staff involvement. On December 10, 2013, he signed an order amending 7 AAC 160.900(d)(30) to require the following physician certification for a state-Medicaid-funded abortion:

> I certify based upon all of the information available to me that . . . in my professional medical judgment the abortion procedure was medically necessary to avoid a threat of a serious risk to the physical health of the woman from continuation of her pregnancy due to the impairment of a major bodily function including but not limited to one of the following. . . .[12]

The regulation then listed twenty-one conditions: diabetes with acute metabolic derangement or severe end organ damage; renal disease that requires dialysis treatment; severe preeclampsia; eclampsia; convulsions; status epilepticus; sickle cell anemia; severe congenital or acquired heart disease Class IV;

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[10] Interrog. Resp. No. 3 to Def's Resp. to Pl's 2nd Disc. Req., August 18, 2014 (Pl. Trial Ex. 47).
[11] *Id.*, Int. Resp. No. 5.
[12] Pl. Trial Ex. 1.

pulmonary hypertension; malignancy where pregnancy would prevent or limit treatment; severe kidney infection; congestive heart failure; epilepsy; seizures; coma; severe infection exacerbated by the pregnancy; rupture of amniotic membranes; advanced cervical dilation of more than six centimeters at less than 22 weeks gestation; cervical or caesarian scar ectopic implantation; pregnancy not implanted in the uterine cavity; and amniotic fluid embolus. Also listed was a category for "psychiatric disorder that places the woman in imminent danger of medical impairment of a major bodily function if an abortion is not performed;" and a category for "another physical disorder, physical injury, physical illness, including a physical condition arising from the pregnancy."

Planned Parenthood filed the present action to declare the regulation unconstitutional. It moved for a preliminary injunction, which this court granted. The court pointed out that the State had operated under Judge Tan's standard of medical necessity for twelve years post *State, DHSS*, and so would suffer no irreparable harm during a short period for judicial review of the new regulation.

Shortly thereafter the legislature enacted Senate Bill 49 (hereafter "SB 49"), codified as AS 47.07.068.[13] The law is nearly identical to the new regulation but lacking a psychiatric disorder category. The Plaintiff amended its complaint, and the court expanded the preliminary injunction. Plaintiff also

[13] Appendix A.

moved for a ruling that the statute impliedly repealed the regulation. The court denied that motion.

The legislative history of SB 49 begins in early 2013. Senator John Coghill, chairman of the Senate Judiciary Committee, sponsored SB 49. Its announced purpose was to define "medical necessity" in light of *State, DHSS.*[14] During the bill's consideration, the House and Senate committees heard testimony from several invited medical professionals.

Priscilla Coleman, Ph.D., a professor of developmental psychology from Kentucky, testified that abortions are a substantial contributing factor to women's mental health problems. She opined that an abortion is never justified on mental health grounds, because abortions exacerbate mental illness, and because abortions can precipitate mental illness in women with no prior history thereof.[15] Under questioning she acknowledged that she is an anti-abortion activist involved in honing the movement's message. She once exhorted the American Association of Pro-life Ob-Gyns to action:

> We need to develop organized research communities to continue the research, apply for grants, recruit young academics, critique data produced by pro-choice researchers, challenge politically biased professional organizations, train experts to testify, and disseminate cohesive summaries of evidence.[16]

Dr. John Thorp, an obstetrician and professor from North Carolina testified next. He testified that he had worked with the bill's sponsor to develop

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[14] Sen. Coghill Sponsor Statement, Sen. Fin. Comm. (3/28/2013).
[15] Sen. Jud. Comm. Min. (Feb. 27, 2013) at 1:56:11 PM, appended as Appendix C, at 6.
[16] *Id.*, at 2:08:51 PM, appended as Appendix C, at 8.

a standard similar to the life-endangerment standard of the federal Hyde Amendment:

> that unequivocally threatened the life of a mother at great magnitude, and would constitute a solid medical indication for a termination of pregnancy. And would be conditions at which even women who wanted to continue a pregnancy, or wouldn't consider abortion, might have it recommended to them as an option to protect their health . . . the bill proposes a comprehensive list of conditions. And hopefully enough specificity and the degree of severity of those conditions that it would be helpful [to the legislature]. . . [and] that would be recommended as options to protect woman's health, even for women who wanted [to] continue their pregnancy or who would not consider abortion.
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> Chairman Coghill: So, [Dr. Coleman's testimony] talked about the psychological health issues. This is talking about the risk to the life [or] the physical health . . . we added in this that the doctor was still the one that talked about anything life-endangering . . . would you consider most of these on the list things you could end up into . . . life-endangering, physical problems?
>
> Dr. Thorp: Yes sir. I think everything on the list . . . would be more likely than not to pose a substantial risk to the life or physical health of a mother-to-be.
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> Chairman Coghill: And for the most part, these came right from the Supreme Court. So, that is why we chose to list them the way the Court had lined them out.[17]

Ob-Gyn Dr. Susan Rutherford testified that the listed conditions comported with her view of medical necessity.[18] She recommended adding a category for fetal abnormalities.[19] She testified that she has only seen one

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[17] Tr. Dr. John Thorp, Pl. Trial Br., Ex. A, pp. 13-14; *see also Id.* pp. 73-74 (indicating Dr. Thorp's close association with Senator Coghill and the Senator's staff).
[18] Sen. Jud. Comm. Min. Feb. 27, 2013, at 2:39:48 PM, appended as Appendix C.
[19] Tr. Dr. Susan Rutherford, Pl. Trial Br., Ex. A, p. 22.

patient in thirty years whose kidney infection justified an abortion. "And we only figured that out after the fact;" in other words after the woman died.[20]

SB 49 was introduced in the House of Representatives as House Bill 173 (hereafter "HB 173"). At a hearing of the House Judiciary Committee on March 29, 2013, Dr. Rutherford informed the committee that she concurred with the conclusions of Dr. Coleman and other researchers that termination of a pregnancy actually worsens the mental health status of the woman. She acknowledged contrary views, but insisted that the weight of the evidence supports the conclusion that abortions only worsen mental health.[21]

Both bills were repeatedly characterized as conforming both to the Hyde Amendment's formulation of rape, incest, and life endangerment; and to the *State, DHSS* mandate for coverage of all medically necessary health conditions.[22] It was suggested that Alaska statutes only lacked for a definition of "medical necessity."[23] The legislature operated under the impression that many of the bill's provisions were taken directly from *State, DHSS*.[24] Legislators apparently had the sense that the bill would satisfy equal protection so long as

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[20] *Id.* pp. 25-26.
[21] House Jud. Comm. Min. March 29, 2013, appended as Appendix C, p. 17.
[22] House Fin. Comm. Min. Feb 25, 2014, at 8:06:25 AM (noting that the language "an abortion must be performed to avoid a treat [*sic*] of serious risk to the life or physical health of a woman from continuation of the woman's pregnancy" had been "taken out of the 2001 Planned Parenthood decision" and also derived from the Hyde Amendment). Appended as Appendix C, pp. 24-25.
[23] House Jud. Comm. Min. March 29, 2013, appended as Appendix C, p. 17.
[24] House Fin. Comm. Min. Feb 25, 2014 (noting that the listed medical conditions had been verified by medical experts, and were also included in *State, DHSS.*), appended as Appendix C, and beginning on p. 24.

its enumerated conditions were based on some recognized scientific standard specific to abortions.[25]

On August 22, 2013, a lawyer from the Legislative Affairs Agency, Division of Legal and Research Services issued a memorandum addressed to Senator Hollis French that evaluated the constitutionality of the proposed abortion regulation.[26] The memo concluded in relevant part:

> The *Planned Parenthood of Alaska* case strongly suggests that the Alaska Supreme Court considers women who carry their pregnancy to term to be similarly situated with women who have an abortion (in that they are both exercising their constitutional freedom of reproductive choice) . . . If the court continues to hold that position when it reviews future case, there is a reasonable possibility that the court will find that the state may not burden the right to abortion services under the state Medicaid program with special certification of a specific type of "medical necessity" unless either a similar burden is placed on medical services to continue a pregnancy or the state can show a compelling state interest . . . the new regulation appears likely to be found unconstitutionally discriminatory.

The extent of the letter's distribution is not of record.

III. FINDINGS OF FACT

The court held a seven-day evidentiary hearing, and now makes the following findings of fact. The first twenty-two findings are based on the testimony of Dr. Aaron Caughey, chairman of the Ob-Gyn Department at the Oregon Health & Science University:

1. The term "medically necessary" derives from the insurance industry rather than medical practice. Physicians more commonly use the term

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[25] *See* Sen. Coghill Memo to Sen. Fin. Comm. April 1, 2013, appended as Appendix B.
[26] Ex. 5 to Pl's Jan. 29, 2014 Memo Re Mot. for TRO and Prelim. Inj., p. 5.

"medically indicated," which signifies that a body of evidence suggests intervention will result in a better outcome. The term "elective" means non-medically indicated, *i.e.* with no attending medical benefit.

2. In humans, maternal blood is completely exposed to the placenta, in order to promote the fetus' large-brain growth. A pregnant woman's immune system may react adversely to paternal antigens present in the placenta, leading to elevated blood pressure and kidney damage, a condition known as preeclampsia, a precursor to numerous modalities of life threatening damage. Preeclampsia is most commonly diagnosed after 24 weeks, and may be analogized to a ticking time bomb. A patient must weigh the advantage to the fetus of each additional gestational week, versus immediate caesarian delivery of a preterm baby, thus relieving the mother of life threatening health risks. Preeclampsia during one pregnancy elevates the risk of reoccurrence in a repeat pregnancy by 15-50%, depending on the timing and severity of the prior occurrence. Preeclampsia entails risk to the mother twenty years in the future for heart disease and stroke, but with no measurable way to quantify that risk at present.

3. The most common condition that complicates a pregnancy in the U.S. is obesity, affecting 34% of pregnancies. Chronic hypertension or gestational diabetes complicates 5-10% of such pregnancies. Less common conditions implicating greater risks include renal disease, autoimmune disorders, cancer, or heart disease.

4. Obese patients have higher than baseline rates for congenital anomalies (birth defects) and miscarriage. Obesity renders imaging modalities less effective, complicating the diagnosis of other conditions. Obese women also experience higher than baseline preterm births and growth disorders, both over- and under-weight. Overweight fetuses are more prone to delivery by c-sections, and to metabolic disorders following their birth. Obese women suffer higher rates of preeclampsia. Preeclampsia affects 5% of pregnant women, but 10-15% of obese pregnant women. In women with morbid obesity, the gestational diabetes rate is 40-50%. Obesity increases the odds of both preterm birth and post-term birth, *i.e.* too short or too long a pregnancy. An over-length pregnancy puts both the mother and the fetus at risk; adverse long-term disorders include higher rates of caesarian delivery, postpartum hemorrhage, uterine infection during labor or post-delivery, and blood clots in the legs or pelvis that may migrate to the lungs. This latter complication is the largest cause of maternal mortality in the United States.

5. Women with chronic hyper-tension (elevated blood pressure) experience higher than baseline rates of miscarriage, preterm birth, preeclampsia, and higher rates of growth-restricted fetuses that require early delivery in the early to mid-third trimester.

6. Women with pre-gestational diabetes suffer the same risk factors as obese women, multiplied by a factor of two. Additionally, the pregnancy affects the diabetes itself. The pregnancy hormones cause increased insulin resistance over the course of the pregnancy, but the degree of resistance varies

throughout the pregnancy. Such women essentially face a new disease pattern each week of their pregnancy, which limits their ability to maintain good control over their insulin levels. Control of such diabetes may become the equivalent of a full time job during pregnancy, requiring the interruption of a career.

7. Women who are pre-diabetic due to weight and diet before pregnancy may become diabetic from the hormones of pregnancy. This is most often diagnosed in the third trimester. Such women experience all the above risk factors, except fetal abnormality.

8. Pregnancy may restrict a woman from utilizing the medication she normally takes for pre-pregnancy conditions. A bipolar patient's use of prescribed lithium may increase the risk of severe fetal heart defect. Typically such a patient will stop her use of lithium during pregnancy.

9. Dr. Caughey credibly provided an example of how factors can interact during pregnancy for a woman with comorbid bi-polar disease and diabetes. To avoid harm to the fetus, a patient discontinued her lithium. She then decompensated from normality to dishevelment and mania. Her control over her diabetes diminished, and she required hospitalization.

10. Many drugs used to control disease pose a risk to a fetus. Chemotherapeutic agents adversely affect fetal development. Many high blood pressure drugs can also impact fetal development. Diabetes patients must stop taking certain medications in favor of a limited class of drugs that are safer for pregnancies. Many antibacterials and antibiotics are not utilized during

pregnancy. Also, new drugs that have not been tested in pregnant women are constantly introduced into the marketplace. The hormones and ensuing metabolic changes of pregnancy, including increased liver and kidney function, can make dosing these drugs difficult. And the hormones of pregnancy can directly affect the performance of drugs. These challenges can make it difficult for a woman to maintain a healthy status during pregnancy.

11. Anti-epilepsy drugs are also teratogenic, *i.e.* they can cause fetal abnormality. An epileptic woman wishing to become pregnant would normally reduce her combination of anti-seizure medications to a sole medication. Proper adjustment and titration can take up to six months.

12. Pregnancy can elevate the frequency of pain crises in women with sickle cell anemia. The fetus elevates the body's production in bone marrow of incongruously shaped red blood cells, which then may become retarded in small blood vessels, causing infarctions.

13. The severe heart disease Class IV listed in the statute is heart disease of sufficient severity that a person is never asymptomatic except possibly at complete rest. Many lesser heart conditions are adversely affected by pregnancy. Blood volume increases by 50% during pregnancy, placing additional demands on the heart. A twenty year old woman may have a relatively asymptomatic heart defect such as a hole between her ventricles, that tips into florid symptoms during pregnancy, entailing a risk of death.

14. Conjoined twins always have to be delivered by a form of caesarian section that will commit the woman to preterm c-sections in all future

pregnancies. Carrying such a pregnancy to term affords only a modest chance of a good outcome for the twins.

15. Some fetuses have virtually no chance of surviving a pregnancy, surviving to age one, or developing mentally.

16. Pre-viability rupture of the amniotic sac can lead to decreased uterine pressure on the developing fetus, causing hypoplasia (low growth) of the fetal lungs.

17. In assessing risk to patients and the best interests of patients, physicians must take into account the social, economic, and other situational life factors that may affect a patient's response to illness or pregnancy. For example, if a woman with diabetes has a night job, that alone decreases the probability that she maintains good control of the disease. If such a person has a child with elevated health care needs, such will predictably degrade the patient's quality of self-care. The marginally housed have difficulty with insulin refrigeration and with self-care in general. Mothers with large families or otherwise stressed family life may also lack the capacity to adequately attend to their own health needs.

18. The statute only captures the very worst medical outcomes, the tip of the iceberg for those conditions and circumstances that would render an abortion medically indicated. The statute thus imposes a higher barrier to funding in the abortion context compared to other non-pregnancy medical needs.

19. Other than by self-injury, psychiatric illness does not generally lead to medical impairment of a major bodily function.

20. Dr. Caughey credibly testified that the field of medicine is not sufficiently advanced to predict outcomes that are distant in time. The challenged statute invites speculation or projection beyond the current medical consensus. Risk factors are probabilistic, but often cannot indicate a particular result for a particular patient.

21. The challenged statute will impose on some poor women costs that will delay or prevent their medically indicated abortion. If a woman begins setting aside funds for an abortion the instant she gets pregnant, and gathers the necessary funds in ten weeks, she will face doubled or tripled risks and a more expensive procedure. The challenged statute will thereby delay or prevent treatment for a wide array of health conditions.

22. Dr. Caughey credibly provided an example of a former patient in low-grade general health who had given birth to seven babies. While it was medically risky for her to have another child, he would have been unable to identify a specific organ more at risk than any other.

Finding No. 23 is based on the testimony of Rebecca Poedy, Executive Director of Planned Parenthood of the Great Northwest:

23. Planned Parenthood physicians performed 1410 abortions in Alaska during 2010. Of these, 474 were Medicaid-funded. Alaskan patients must travel to Seattle for second-trimester abortions, because there are no providers in-state. The Planned Parenthood fee for an abortion is $650-750 during the

first trimester, and $900-1000 during the second trimester. Alaska Medicaid pays travel expense, including travel to Seattle.

Findings Nos. 24-30 are based on the testimony of Dr. Renée Bibeault, who practices in Washington as a general and perinatal psychiatrist:

24. Mental distress that rises to the level of a psychiatric disorder is a state of altered or disturbed emotion characterized by negative emotions, fear, anguish, sadness, and difficulty coping with life. It is to be distinguished from normal sadness, or a normal or culturally approved response to loss. There is no recognized articulable standard to distinguish psychiatrically significant mental distress from normal sadness; the determination is made experientially by a treater.

25. Pregnancy is a complicated psychological event which is quite stressful for a majority of women, whether or not the pregnancy is a desired one. It can be a destabilizing event for a woman's mental health. Reproductive hormones affect brain chemistry. Previous mental health conditions can recur during pregnancy. Pregnancy can spark or exacerbate mood disorders that disturb ongoing emotional equilibrium, and that entail sadness, emptiness, and depression. Included in this spectrum are disorders of anxiety, adjustment, schizo-affect, and substance abuse. Such disorders may extend to or originate in the postpartum period (*i.e.* six months post-delivery).

26. Pregnancy and delivery are out-of-control events entailing substantial physical discomfort. The implications of child-raising, of job changes and stresses, and of relationship effects can be overwhelming to a

particular woman. Altered kidney function during pregnancy can alter a woman's response to medication or make dosing difficult. Accordingly, pregnancy may present a substantial barrier to effective treatment of mental illness.

27. A given psychiatric medication may have a 50-60% likelihood of effectiveness in a particular patient. Trial periods of 12-14 weeks, to gauge effectiveness, are normal. Some medications must be tapered off rather than abruptly discontinued. Further, if a woman on psychiatric medication becomes pregnant, changing her medication to avoid fetal toxicity can raise serious health issues. If such a woman elects to go off psychotropic medication, ensuing changes to her psychiatric state and resultant behavioral changes may pose a serious risk to the health and safety of the fetus.

28. Dr. Bibeault credibly testified to the following illustrative mental health circumstances where pregnancy served as a trigger for psychiatric symptoms:

> a) A second-grade teacher with obsessive compulsive and anxiety disorders who experienced repetitive thoughts and behaviors, including the need to tap her desk a number of times before responding to a student, became stabilized on medication for a period of years. When she became pregnant her compulsions returned. She became sufficiently dysfunctional that she elected to terminate an otherwise wanted pregnancy.

b) Similarly, a high-functioning young woman underwent three miscarriages in eighteen months. Each pregnancy was attended by depression and anxious concern for the fetus. She became psychotic during the third pregnancy. Her symptoms cleared within two weeks of each miscarriage.

c) A woman with an eating disorder became pregnant and went off psychiatric medication. She became depressed and suicidal. Termination of her pregnancy resolved her extreme mental anguish.

d) A woman with pregnancy-induced depression wished to have an abortion but did not do so due to intense family pressure. Her illness intensified postpartum into psychotic depression requiring hospitalization. She underwent electro-convulsive therapy, which disturbed her memory and cognition. She has formed very little bond with her six-year-old twins.

e) A victim of domestic violence by an abusive husband wished to flee the relationship, but was frantic that carrying her fetus to term would tie her to her abuser.

f) A young woman was impregnated by her psychotherapist. The patient presented as anxious, grieving and betrayed.

29. It is relatively rare for a mentally ill pregnant woman to be at risk for suicide or extreme self-neglect. The mental health exception in the DHSS regulation is accordingly extremely limited.

30. Dr. Bibeault credibly testified that in her clinical practice she has observed that abortions can relieve great mental suffering and improve mental stability.

Findings Nos. 31-36 are based upon the testimony of Dr. Samantha Meltzer-Brody, who is an associate professor of psychiatry at the University of North Carolina at Chapel Hill:

31. Fifty percent of all pregnancies are unplanned, and some smaller percentage are unwanted. An unplanned, unwanted pregnancy is a profound stressor for a woman. Particularly in women with prior history of mental illness, pregnancy can result in debilitating symptoms leading to total or near-total incapacitation.

32. Ten to fifteen percent of pregnant women experience major depression, and one in seven experiences psychiatric illness in some form. These statistics increase in the poverty-stricken population. Termination of hormonal fluctuations via abortion may end or ameliorate the symptoms of such patients.

33. For women who do not wish to revisit prior profound mental illness symptoms of previous pregnancies, abortion is medically indicated.

34. Dr. Meltzer-Brody credibly furnished several anecdotal examples from her practice:

a) A patient who suffered from mental illness presented naked, smeared with feces, and compulsively masturbating. The patient's pregnancy aggravated her condition.

b) An attorney experienced extreme depression during a first pregnancy, likely brought on by extreme hormonal fluctuations. She took years to recover. Her depression recurred during a second, wanted pregnancy. She became totally incapacitated, but recovered after terminating the pregnancy.

35. Upon becoming pregnant, women are generally advised to cease taking psychotropic drugs, such as lithium, Depakote, and Tegretol, which are attended by an increased risk of fetal abnormality. The main risk to a fetus from its mother ingesting lithium is a disorder called Epstein's anomaly. This occurs less than one percent of the time. Because there is an enormous social stigma against taking medications potentially adverse to a fetus, many women will cease taking medication, even when doing so goes against their best interests.

36. Substance abuse disorder is a recognized category of mental illness. Dual diagnoses of substance abuse disorder plus an axis one psychiatric disorder in a pregnant woman presents grave challenges.

Finding No. 37 is based on the testimony of Dr. Sharon Smith, a family practitioner at the Anchorage Neighborhood Health Center:

37. Dr. Smith credibly testified regarding situations where a physician practicing without legislative restraints would normally consider an abortion medically indicated. She gave the following examples:

a) A patient was desperate to terminate her pregnancy because she could not continue to be employed with another baby, such that

her family would lose half its income. She was extremely distraught. Her abortion was necessary for her health.

b) A patient's fetus presented with a lethal anomaly; the baby would have only survived an hour or two after birth. Because no physician in Fairbanks would treat her, the patient came to Anchorage, extremely distraught. Dr. Smith considered that any denial of Medicaid funding forcing the patient to carry her baby to term would be tantamount to torture.

c) A patient presented with a toxic alcohol condition. Her husband had AIDS. She was unable to stop drinking, and her pregnancy was an extreme stressor. Without an abortion, her fetus would have been born with fetal alcohol syndrome disorder.

d) Some patients are in serious domestic violence relationships. Having a child with the abuser tends to tie the mother to her abuser, with potentially fatal results.

Findings Nos. 38-39 are based on the testimony of Dr. Eric Latzman, an Ob-Gyn who works several days a month on contract for Planned Parenthood:

38. Dr. Latzman credibly testified that Planned Parenthood uses the standard set forth by Judge Tan in his injunctive order. In other words, an abortion is medically indicated if it will ameliorate a condition harmful to the physical or psychological health of the patient in the professional judgment of the treating physician. He generalized that approximately one-third of the time the abortion decision is driven by specific medical conditions, and two thirds of

the time by psychological factors, such as anxiety, depression, addiction disorders, or personality disorders. He has never concluded that an abortion is other than medically indicated when a woman wishes to terminate her pregnancy. Planned Parenthood does not log the reason why it considers an abortion to be medically indicated. Dr. Latzman takes from two to ten minutes to confer with patients to determine that an abortion is medically indicated. He would not perform a Planned Parenthood abortion for a woman with a statutorily listed condition, simply because such women are too ill to utilize a Planned Parenthood clinic. The statute would effectively eliminate all Medicaid-funded abortions at Planned Parenthood.

39. Dr. Latzman cited as an example of psychological factors a sixteen-year-old adolescent from the Yukon-Kuskokwim Delta, pregnant due to a birth control pill failure. She was a high-performing student who expected to attend college. She had been sexually abused from the age of four. She had very little family support. Following the pregnancy, she had ceased eating and was unable to function in school. Dr. Latzman considered her abortion to be medically indicated.

Findings Nos. 40-44 are based on the testimony of Dr. Jan Whitefield. Dr. Whitefield is an Ob-Gyn who provides contract services to Planned Parenthood.

40. About one third of the Planned Parenthood patients Dr. Whitefield sees are on Medicaid. Planned Parenthood charges $650 for an abortion. The normal cost of prenatal care for a woman carrying to term in Anchorage is

$8300 to $9000, and much more for a complicated pregnancy, not including hospital charges. Dr. Whitefield opined that $650 is a very substantial amount of money for women of the Medicaid population. The time necessary for a woman to acquire that sum could take a woman past the twelve-week *de facto* limit to obtain an in-state abortion, given that there are no surgical centers willing to provide abortion services in Alaska.

41. Like Dr. Latzman, Dr. Whitefield has never found that an abortion is other than medically indicated. His definition of medically indicated is a practical one: if a patient has a problem and an abortion will help resolve the problem, the abortion is medically indicated.

42. Dr. Whitefield begins his patient interview with the question, "Why are you here today?" He encounters women whose resources are stretched to the limit; women with a defined mental disorder, exacerbated by the pregnancy; women in bad relationships, sometimes deathly afraid of a partner; and women whose pregnancy will derail their ability to escape from poverty and become independent. He does not attempt to diagnose depression according to the standards of the DSM V manual, but rather assesses overall psychological health.

43. Dr. Whitefield considers the "serious bodily function" standard of the challenged statute to be extremely stringent, such that very few women would satisfy it. The statute would effectively eliminate Medicaid-funded abortions at Planned Parenthood clinics.

44. If the statute were interpreted expansively to apply to women subject to a "risk of a risk" of serious complications, that means all women. For example, all women are at risk for conditions such as preeclampsia.

Finding No. 45 is based on the testimony of Jonathan Sherwood, DHSS Deputy Director of Medicaid and Health Policy:

45. Alaska Medicaid expends over one billion dollars per year on Medicaid services. Alaska Medicaid expends less than two hundred thousand dollars on abortions.

Findings Nos. 46-53 are based on the testimony of Cindy Christensen, a Health Program Manager IV at DHSS Division of Health Care Services:

46. Contrary to normal DHSS procedure, Commissioner William Streur developed the abortion regulation on his own. DHSS staff did not participate in the drafting of the regulation. The DHSS medical director played no role. No abortion providers were consulted.

47. The Alaska DHSS has no omnibus definition of "medical necessity" by which it determines whether medical services are covered by Medicaid. The DHSS generally presumes that a physician provided a medically necessary service.

48. Medicaid pays for tubal ligations of all who request one. The surgeon's fee for this is $1,900, which does not include hospitalization expense.

49. Scheduled c-sections do not require pre-approval via certification of their medical necessity.

50. State Medicaid covers family planning services including sterilization, vasectomy, birth control pills, and IUDs.

51. A typical hospital delivery costs Medicaid approximately $12,000.

52. Medicaid funds many behavioral health services, including drug addiction and family counseling services.

53. Medicaid pays for breast reconstruction surgery, considering it necessary for the emotional wellbeing of the affected woman. Medicaid will pay for a specialist to tattoo a nipple and an areola to perfect the reconstruction. Medicaid will fund revision of a disfiguring injury to reduce stigma and psychological suffering. Medicaid will pay for removal of a disfiguring facial growth that causes emotional distress.

Findings Nos. 54-58 are based on the testimony of Minnesota Ob-Gyn Steve Calvin:

54. Dr. Calvin identifies himself as pro-life. He opined that under the statute an abortion is medically necessary when a continuation of a pregnancy poses a threat to the life of the mother.

55. C-sections are the most common major surgery in the United States. Approximately one-third of pregnant American women give birth by c-section.

56. Three to four fetuses per thousand have an anomaly that is incompatible with life. These include anencephaly (absence of brain covering), absent kidneys, and uncorrectable chromosomal problems. Such fetuses, carried to term, will not survive. In his practice, Dr. Calvin considers abortions

for lethal fetal anomaly to be medically necessary; he has participated in approximately forty such abortions

57. The physical stresses imposed by a pregnancy can cause a woman with heart disease to advance to a higher class of functional incapacity.

58. Silent dilation of the cervix during a pregnancy places the amniotic sac at risk of infection from the genital tract. Such a woman is at serious risk.

Findings Nos. 59-64 are based on the testimony of Dr. Eileen Ryan, who is an associate professor of psychiatry at the University of Virginia:

59. Pregnancy can trigger mental illness. Particularly if a woman is predisposed to mental illness, pregnancy can be an especially vulnerable time for its expression. The postpartum period presents particular vulnerabilities for the expression of major depressive disorders. Hormonal changes during pregnancy, and the significant rapid decline in estrogen and progesterone after birth, are thought to be a factor in postpartum depressions. Up to 20% of pregnant women will at some time experience a pregnancy-related depressive disorder; 9% will suffer a major depressive disorder. For women with pre-existing bipolar disorder, 20-25% will experience depression or mania during or after pregnancy.

60. If a woman has experienced a postpartum depression, and particularly one with psychotic features, the likelihood of recurrence after a succeeding pregnancy is significantly elevated. It is unknown whether early termination of pregnancy affects the likelihood of such depression.

61. A psychiatric disorder is one that meets the criteria expressed in the DSM V Manual. Emotional distress plus impairment of function is not the same as a DSM-recognized psychiatric disorder. Situationally, termination of a pregnancy might ameliorate emotional distress with impairment of function. But an abortion is not recognized as a formal treatment of a psychiatric disorder meeting DSM criteria, or a cure thereof.

62. Women who take the bipolar medication Depakote during pregnancy face a 10% risk of some major deformation to the fetus, including placement on the autism spectrum or a decrease in IQ. Research suggests that such women are 12.7 times more likely to give birth to a baby with spina bifida than a non-medicated woman; 0.6% of Depakote-exposed babies will suffer from spina bifida.

63. Abortion is medically indicated in instances of fatal fetal anomaly. In cases of anencephaly or Tay-Sachs disease, a delivered baby will undergo significant suffering pre-death.

64. Dr. Ryan was not asked to, and did not, support the testimony of Dr. Coleman and Dr. Rutherford before legislative committees that abortions cause mental illness or exacerbate pre-existing mental illness.

III. APPLICABLE LAW

When interpreting statutes, Alaska courts adhere closely to the text's plain meaning. Courts may consider alternate interpretations as suggested by legislative history. But where a law's text is clear and unambiguous, the

legislative history must be increasingly compelling to overcome the statute's apparent plain meaning:

> When we interpret this statutory language we begin with the plain meaning of the statutory text. The legislative history of a statute can sometimes suggest a different meaning, but "the plainer the language of the statute, the more convincing contrary legislative history must be." "Even if legislative history is 'somewhat contrary' to the plain meaning of a statute, plain meaning still controls."[27]

IV. DISCUSSION

a) Statutory Construction.

The State and Plaintiff interpret the statute very differently. The State reads it as a broad authorization for a physician to perform abortions and thus avoid non-trivial physical health detriments that the physician can concretely name. Plaintiff reads it as the Hyde Amendment in disguise, effectively a life-endangerment standard. These disparate readings suggest a lack of clarity in the statute. The court finds the statute to some extent susceptible to both interpretations. But the legislative history convinces the court that the legislature intended the provision as a high-risk, high-hazard standard that would preclude funding for most Medicaid abortions.

The concepts of risk and hazard are often confounded. Here the statute deals with the effects of an action, "continuation of the pregnancy." That action can entail a risk. The word "risk" in this context fairly connotes statistical likelihood and imminence, both captured by the statutory phrase "serious risk." "Hazard" connotes the bad outcome that is risked and sought to be

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[27] *Hendricks-Pearce v. State, Dept. of Corrections*, 323 P.3d 30, 35-36 (Alaska 2014) (internal citations omitted).

avoided. The statutory hazard is "death" or "impairment of a major bodily function." Neither "impairment" nor "major bodily function" is further defined. But "impairment" is qualified; the impairment must arise from one of twenty-one discrete adverse health conditions, or fall into a catch-all category for other physical conditions subject to like parameters of risk and hazard.

Plaintiff plausibly argues that the plain wording of the statute sets a high-risk high-hazard bar for Medicaid-funded abortions. Not just any adverse health effect of continuing the pregnancy qualifies. A woman is only eligible for state funding if she suffers one of the enumerated conditions, or that condition is imminent. By limiting causation of the impairment to blindingly obvious, highly deteriorated physical health conditions, the statute assures that the health detriment is significant and verifiable. Thus a physician's judgment that a pregnant woman's pre-existing kidney disease would get worse during pregnancy would not justify a funded abortion, because the health detriment did not arise from "renal disease that requires dialysis," as required by the statute. And Plaintiff convincingly argues that the hazardous condition must be, if not fully realized, at least imminent:

> The Statute's restrictive terms and detailed list of eligible conditions—many of which are deliberately qualified with the word "severe" or comparable language—make overwhelmingly clear that the Legislature did not intend for the definition to encompass all medical conditions that *potentially* could pose a serious medical risk, regardless of how distant, as Defendants contend.[28]

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[28] Pl's Jun. 20, 2014 Reply to Def's Opp'n to Pl's 2nd Mot. for TRO, at p. 15 (emphasis in original).

The State reads the statute quite differently. The purport of the statute is not to limit abortions to women at risk of impairment from a select few obvious health catastrophes. Rather, it is to put an end to the funding of truly elective abortions by using a purely physical standard, without resort to the soft social, emotional, psychological, economic, or behavioral factors that Planned Parenthood physicians routinely use to qualify all abortions as medically necessary. Thus the State argued during final summation that the court should interpret the abortion funding statute's "threat of a serious risk" language fairly broadly. In other words, the statute authorizes an abortion when there is any non-trivial possibility (*i.e.* beyond the baseline risk inherent in all pregnancies) that a cited condition might ensue in the future, even if such risk could not fairly be characterized as either serious or imminent. The State argued that the statute leaves

> a lot of room for the doctor's discretion to operate here, and there is no reason to read the statute as somehow foreclosing that sort of freedom for the doctor and patient together to make an assessment about the risk and where they fall in this coverage . . . . All the physician has to do is apply professional judgment, look at relevant factors to determine that there is a physical issue here . . . . [The legislature thinks] the best way is to tie medical necessity to a physical health condition [related to a] major bodily function, not morning sickness.[29]

But the legislative history is consistent only with a hard-core standard based on definitive bright lines. Dr. Thorp, who helped draft the bill, testified that the standard entails conditions so present and so dangerous that even a pro-life

[29] State's Final Argument, Feb. 25, 2015 at 11:47:47 AM.

Ob-Gyn would advise a pro-life patient who desired to carry to term to have an abortion for her own safety.

Plaintiff's medical experts testified that women with the enumerated conditions are so sick that they would not be eligible for a clinic abortion. The explicitly catastrophic nature of the enumerated conditions in the statute and the regulation, viewed in the light of the legislative history, contradicts the State's statutory construction. The phrase "a threat of a serious risk to the physical health of the woman from continuation of her pregnancy" cannot reasonably be read to mean a mere distant "risk of a serious risk." Indeed, Dr. Caughey and Dr. Whitefield testified that all pregnancies entail a risk that a serious risk will arise. There is no indication in the legislative history that "a threat of a serious risk" means anything less than "a serious risk." The word "threat" in the statute must be taken as a mere reiteration of the phrase "serious risk." Read thusly the statute addresses "a threat [consisting] of a serious risk to the physical health of the woman," and not merely possible remote risks.

The court concludes that the statute recognizes as medically necessary only abortions required to avoid health detriments attributable to the enumerated conditions, either fully realized or demonstrably imminent. The catch-all twenty-second category applies to unspecified physical conditions of like gravity and imminence. [30] The regulation's mental health category

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[30] *See Theresa L. v. State, Department of Human Services, OCS,* Op. No. 7029 p.18 (August 7, 2015) (non-exclusive listing of illustrative conditions implies that non-listed conditions should be of equal gravity).

implicates a "psychiatric disorder that places the woman in imminent danger of medical impairment of a major bodily function if an abortion is not performed." No testifying witness propounded any hypothetical beyond that of a full-fledged psychiatric disorder per DSM V criteria that posed an imminent risk of suicide. The State conceded as much in final argument,[31] and the court so finds.

b) The statute as construed violates state equal protection under the holding of *State, DHSS.*

The *State, DHSS* decision applied strict constitutional scrutiny to a regulation limiting Medicaid funding of abortions to cases of rape, incest, or life endangerment of the mother:

> The regulation at issue in this case affects the exercise of a constitutional right, the right to reproductive freedom. Therefore, the regulation is subject to the most searching judicial scrutiny, often called "strict scrutiny." We have explained in the past that such scrutiny is appropriate where a challenged enactment affects "fundamental rights," including "the exercise of intimate personal choices." This court has specified that the right to reproductive freedom "may be legally constrained only when the constraints are justified by a compelling state interest, and no less restrictive means could advance that interest.[32]

The Court then provided examples of care it deemed medically necessary. It characterized denial of such case as discrimination due to State disapproval of abortions. The Court held that this discrimination violated the equal protection clause of Alaska's Constitution. This was so under strict scrutiny, or even under a lower rational-basis standard.[33]

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[31] State Final Argument, February 25, 2015 at 11:51:40 AM.
[32] *State, Dept. of Health & Social Services v. Planned Parenthood of Alaska, Inc., supra* note 1 at 909.
[33] *State, DHSS*, 28 P.3d at 912 ("DHSS's differential treatment of Medicaid-eligible Alaskans

The legislature's response, enacted some fourteen years later, was to expand the unconstitutional 2001 regulation by nominally adding a health endangerment component to its definition of medical necessity. But the statute remains problematic in that it only applies to situations where the woman's health is so compromised that, in general, she suffers a risk of death. The purported broadening of the standard is largely illusory because the enumerated conditions would likely qualify for federal Medicaid funding under the life-endangerment standard of the Hyde Amendment. And the statute completely fails to cover several deprivations of medically necessary care noted in the *State, DHSS* decision, including for women who must choose between the risks of teratogenic effects of psychotropic medications needed for their bipolar or epileptic status, versus real but sub-catastrophic health risks if they forego these medications; and for women who require months in order to self-fund their procedures and so incur increased medical risk due to the delay. The State argues that these examples in *State, DHSS* are *dicta* because hypothetical scenarios were unnecessary to the decision. But the scenarios are more aptly characterized as important descriptors of the amplitude of "medical necessity" as that phrase is used in *State, DHSS.*

The statutory standard limits Medicaid funding to high-risk high-hazard situations while failing to address serious but less-than-catastrophic health detriments. This can readily be seen by reviewing the American Heart

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violates equal protection under rational basis review as surely as it does under strict scrutiny. Under any standard of review, "the State may not jeopardize the health and privacy of poor women by excluding medically necessary abortions from a system providing all other medically necessary care for the indigent." (internal citation omitted)).

Association's classification system for patients suffering heart disease.[34] Class I patients suffer some form of cardiac disease, be it occluded arteries, valvular problems, ventricular fistulae, or the like. But they are functionally asymptomatic. Class II patients experience fatigue, palpitation, dizziness, or angina with ordinary activity. Class III patients experience those same symptoms but with less than ordinary activity. And Class IV patients are unable to carry out any physical activity without discomfort, and may even experience symptoms at rest.

A woman occupying any of those categories may experience dramatic impacts during pregnancy. Blood volume increases by fifty percent, placing an added demand on the heart. A variety of pregnancy-induced conditions including preeclampsia can dramatically increase blood pressure and damage the heart. Dr. Calvin testified that a pregnancy can permanently advance a woman's functional capacity class by one level. Yet the statute only addresses the direst status, Class IV, which must be either fully realized or imminent. Notably, in other contexts Medicaid routinely funds statins, blood thinners, and blood pressure medication to minimize the risk of symptom development from class to class. Each class progression entails huge implications for the quality of a woman's daily life, her work, and her family. Inexplicably the statute discriminates against women who opt for an abortion in order to avoid a risk of such a critical but sub-catastrophic deterioration of their health.

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[34] Filed in open court by Planned Parenthood and now marked as Trial Ex. 53 for identification.

Juveniles also face a discriminatory impact. Under Alaska's parental notification statute, juveniles who seek abortions without alerting parents to their pregnancy may seek authorization by a judge.[35] This "judicial bypass" safety valve is required by the U.S. Supreme Court.[36] It protects juveniles who would likely suffer assault, abuse, or familial rejection, were they to disclose to parents. Yet the Medicaid funding statute effectively nullifies that right by denying a Medicaid-funded abortion to juveniles who lack economic means. At final argument the State was clearly troubled by the example of a hypothetical twelve-year-old impregnated by a fifteen-year-old. The State instead argued that such a young child should lodge an "as applied" constitutional challenge; it did not suggest how she might fund that expensive and time-consuming lawsuit.

The statute denies funding to resolve fetal anomalies, even lethal fetal anomalies where a delivered infant will suffer an inevitable and at times painful death. Dr. Caughey termed this deficiency "unconscionable." The State's experts agreed that such abortions are medically necessary. The statute also denies coverage for non-lethal but still grave fetal abnormalities limiting life quality or life expectancy that a woman may deem well beyond her capacity to manage, and that will cause her extreme emotional distress and detriment to her general health. And the statute denies a Medicaid abortion to a woman whose inability to overcome addiction virtually guarantees that she will deliver

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[35] AS 18.16.020; AS 18.16.030.
[36] *Bellotti v. Baird*, 443 U.S. 622 (1979).

a baby debilitated by prenatal exposure to drugs or alcohol. This denial of coverage in instances of fetal abnormality is wholly uncharacteristic of, and at odds with, the more universal tendency of Medicaid to assuage dire medical outcomes.

Nor do mental illness or extreme emotional distress qualify. The legislation's sponsors argued that mental health considerations can never justify an abortion. They cited Dr. Coleman, who testified that an abortion uniformly worsens a woman's mental health, or can itself trigger mental illness. But a countervailing body of medical researchers regards that view as a canard. In any event, the State did not present Dr. Coleman's rationale at trial. Instead psychiatrist Eileen Ryan testified that an abortion is not formally recognized by the DSM V manual as a treatment modality or cure for mental illness; only DSM-style treatments should qualify for Medicaid funding. And Dr. Ryan testified that only a psychiatric disorder of such severe magnitude as to require hospitalization should qualify. As to women severely distressed by a fetal anomaly, their remedy is to have an "elective" abortion. Her exception for lethal fetal anomalies arose not from the mental state of the mother, but from the likelihood that a non-survivable defect would cause an infant physical suffering after a live birth.

But credible expert testimony by Dr. Bibeault and Dr. Metzler-Brody established that an abortion can in fact resolve psychiatric symptoms of women with anxiety, depression or obsessive-compulsive disorders. It can also be critical in the management of patients suffering psychotic breaks or

schizophrenia. It seems hardly controversial that a schizophrenic woman who presents as naked, smeared with feces, and compulsively masturbating, as described by Dr. Meltzer-Brody, is an obvious candidate for a medically-necessary abortion, even if that abortion will not "cure" her condition. The pregnancy will limit the range of psychoactive medication that such a patient can receive; she may lack the resiliency to withstand constant hormonal surges.

Simply put, an unwanted pregnancy is a crisis for any woman. To an impoverished woman without recourse to an abortion, the crisis may be extreme. Indigent women often face a panoply of stressors, including large families, homelessness, addiction, their own adolescent immaturity, and domestic violence. The added stressor of an unwanted pregnancy with no recourse to an abortion can create clinically significant mental distress such that a Medicaid abortion is medically necessary.

How did the State justify these exclusions from Medicaid coverage? Dr. Calvin and Dr. Bramer, self-identified pro-life physicians, testified in favor of a high-risk high-hazard standard. In Dr. Calvin's case, his testimony was at odds with his home state's definition of medical necessity: Minnesota Medicaid funds all abortions. Notably, Dr. Calvin cannot be seen as testifying to some universally recognized standard of practice. Rather, he advocated the proposition that "medical necessity" should mean "necessary to avoid fatal or near-fatal health crises." But he never explained why that should be so. Viewed thusly his testimony amounted to an *ipse dixit*: he approved of a high-

risk high-hazard standard for Medicaid abortions because such a standard accords with his personal religious precepts against abortion. Psychiatrist Dr. Ryan was similarly dogmatic: the only medically necessary psychiatric treatments are medications or therapy for formally diagnosed psychiatric disorders. An abortion is not such a treatment. Amelioration of mental suffering via an abortion is not medically necessary because this would contradict her personal moral standards.

The State has identified no other context in which medical service to poor people is titrated with such exacting rigor, with such indifference to risk factors, to sub-catastrophic physical heath detriments, and to human suffering. In numerous other contexts, Medicaid relieves human suffering unrelated to serious end-organ damage. Medicaid will cover procedures to remediate disfiguring conditions, not because such conditions seriously impair a major bodily function, but because doing so relieves great emotional distress. The essential humanity of the program is symbolized by its willingness to spend thousands of dollars for a realistic tattoo of an areola and nipple on a woman's reconstructed breast. Medicaid will provide behavioral counseling for the family of an errant youth. It will fund an expensive elective tubal ligation or vasectomy; or drug or alcohol counseling for the addicted; or non-emergency caesarian sections, without elaborate standards. And when Medicaid curtails spending, it does so for genuinely neutral reasons. When unscrupulous group homes peddle surplus diapers, DHSS sensibly imposes a per-patient quota. No constitutional principle is implicated.

But under AS 47.07.068, abortions for poor women are subject to an entirely different register of scrutiny. Medicaid will pay $9,000 in routine prenatal care and $12,000 in routine delivery expense for a pregnancy where a poor woman elects to carry to term in the face of significant risks. But it cannot pay $650 for the same poor woman who is unwilling to bear those risks and who exercises her constitutional right to terminate her pregnancy. The court is aware of no other context where Medicaid engages in such a relentlessly one-sided calculus.

The equal protection issue posed in *State, DHSS* was whether the standard applied to women seeking abortions accorded with Medicaid treatment of patients in general. This court must gauge whether the statute's high-risk high-hazard standard is compatible with the broad tendency of Medicaid to defer to a physician's judgment the question of what treatment is medically necessary to advance physical and mental health, taking into account the patient's individual nature and specific life circumstances.

The State resists this court's frame of the equal protection issue, arguing that this is not an equal protection case at all. It instead contends that the statute complies with the *State, DHSS* holding by adding a health-of-the-woman component; and that the legislature applied neutral criteria, *i.e.* the testimony of medical professionals, in formulating the standard. Per the State, the interest at stake is purely monetary, *i.e.* the $650 cost of abortions. A rational-basis standard applies, not the strict scrutiny of *State, DHSS*. The statute is neither pro- nor anti-abortion; it simply reflects a mundane drawing

of lines pursuant to neutral criteria, just as DHSS limits diaper allocations to group homes.

But the court concludes that the legislature fundamentally misunderstood *State, DHSS.* The Supreme Court clearly held that the relevant standard of medical necessity is that applied by Medicaid to its general population. In contrast, the legislature uncritically accepted the testimony of self-identified anti-abortion advocates promoting a fabricated consensus on medical necessity. Impelled by this contrived testimony, the legislature then enacted a minimal tweak to the restrictive Hyde Amendment standard of rape, incest, or life endangerment. The State at trial presented similar self-identified pro-life advocates. It too contended that the high-risk high-hazard standard is neutral because neutral pro-life physicians endorse it. The State's credulous analysis is incompatible with the holding of *State, DHSS.* The high-risk high-hazard standard of the statute and DHSS regulation denies low-income women seeking Medicaid abortions the equal protection of Alaska law.

c) What standard for Medicaid-funded abortions accords with the equal protection holding of *State, DHSS*?

Having concluded that AS 47.07.068 sets the bar for Medicaid-funded abortions too high, this court could decline to define a standard that is actually consistent with *State, DHSS.* Courts often avoid broader than strictly necessary holdings in constitutional litigation for sound prudential reasons. But here the parties have with great professionalism and skill conducted a comprehensive evidentiary hearing on the issue of election versus necessity. The parties fairly

invite this court to declare an appropriate standard. The Alaska Supreme Court will decide the matter *de novo*, without deference to this court's decision. But some defined standard should prevail during the period of Supreme Court review.

For nearly fifty years Alaska Medicaid has operated under a physician-deferential standard of medical necessity in the abortion context. That standard was articulated in Judge Tan's 2000 order:

> [T]he terms medically necessary abortions or therapeutic abortions are used interchangeably to refer to those abortions certified by a physician as necessary to prevent the death or disability of the woman, or to ameliorate a condition harmful to the woman's physical or psychological health, as determined by the treating physician performing the abortion services in his or her professional judgment.[37]

The State proved at trial that Planned Parenthood physicians uniformly certify a Medicaid abortion as medically necessary. The State argues that Judge Tan's standard is so broad and nebulous that it permits a doctor to consider factors it believes should be irrelevant to medical decision-making. These include social and economic considerations. Does the woman have a large family under stress from multiple factors such as poverty, unemployment, lack of housing, domestic violence, and the like? Does the woman suffer from drug addiction, or exhibit reckless adolescent immaturity, or other behaviors signaling an inability to parent? Is a young woman, forced by poverty to carry to term absent Medicaid funding, subject to extreme

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[37] Judge Tan Order (Sept. 18, 2000), (attached to Pl.'s Jan. 29, 2014 Memo Re Pl.'s Mot. for TRO and Prelim. Inj., Exhibit 3).

emotional distress over loss of an educational opportunity that is her sole hope for an escape from poverty and social disarray? Recognition of such concerns, the State argues, is incompatible with an effort to preclude truly elective abortions.

In contrast Plaintiff's physicians consider life circumstances and mental health to be critically important. To Dr. Whitefield, his introductory question to a patient, "Why are you here?" always elicits a response that places the patient somewhere along the spectrum of medical necessity. "Medically necessary," a term mainly used in the insurance industry to deny claims, is thereby recast into the term that doctors more commonly use, "medically indicated." A procedure is medically indicated if it would result in some benefit to the patient. Dr. Whitefield's inquiry to his patients leads either to an inevitable conclusion of medical necessity, or to a decision by the woman that she does not wish to proceed with an abortion.

The court, in resolving these disparate contentions of the parties, finds guidance in *State, DHSS*. First, the Alaska Supreme Court explicitly described conditions qualifying as medically necessary. For example, the Court telegraphed that a bipolar woman taking psychotropic medications should be entitled to a funded abortion to avoid risk of injury to the fetus or to her own mental health. The Court also suggested that a delay of months while a woman raises the money for an abortion adds unacceptable risk. This court concludes deductively that *State, DHSS* signals the Alaska Supreme Court's intolerance toward subjecting impoverished Alaskan women to non-trivial and

avoidable physical risks, to material mental health detriments, or to mental distress due to serious fetal anomalies.

Moreover, the *State, DHSS* Court highlighted the U.S. Supreme Court case *Roe v. Wade* as an underpinning of Alaska law:

> Under the U.S. Supreme Court's analysis in *Roe v. Wade,* the State's interest in the life and health of the mother is paramount at every stage of pregnancy. And in Alaska, "[t]he scope of the fundamental right to an abortion ... is similar to that expressed in *Roe v. Wade.*" Thus, although the State has a legitimate interest in protecting a fetus, at no point does that interest outweigh the State's interest in the life and health of the pregnant woman.[38]

Roe v. Wade is commonly thought of as legalizing abortion; in fact, *Roe* only legalizes *medically necessary* abortions. Yet no state prosecutes physicians providing, or women undergoing, elective abortions. This is largely because on the same day that the U.S. Supreme Court decided *Roe v. Wade,* it also decided *Doe v. Bolton,*[39] and ordered that the two be read together.[40] *Bolton* held that a Georgia criminal statute restricting abortions to those that are medically necessary was permissible, in light of the Georgia statute's broad definition of "medical necessity":

> We agree with the District Court that the medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage, of the pregnant woman.[41]

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[38] *State, Dept. of Health & Social Services v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904, 913 (Alaska 2001).
[39] *Doe v. Bolton,* 410 U.S. 179 (1973).
[40] *Roe,* 410 U.S. at 165.
[41] *Bolton,* 410 U.S. at 192.

Then in 1980 the U.S. Supreme Court case *Harris v. McRae* upheld the federal Hyde Amendment and state statutes with a similar life-endangerment, rape, or incest standard as permissible under the U.S. Constitution.[42] The *Harris* holding and its rationale are set forth in the Massachusetts case *Moe v. Sec'y of Admin. & Finance*:

> In *Harris v. McRae* and its companion case *Williams v. Zbaraz*, the Supreme Court of the United States upheld enactments substantially identical to those challenged here against claims that they violated the due process and equal protection components of the Fifth and Fourteenth Amendments to the United States Constitution. In the view of five members of the Court, neither the Federal nor the parallel State funding restriction denied any federally protected constitutional right. While granting the importance of a woman's interest in protecting her health in the scheme established by *Roe v. Wade*, supra, the Court held that "it simply does not follow that a woman's freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices. The reason why was explained in *Maher v. Roe*: although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls in the latter category.... Although Congress has opted to subsidize medically necessary services generally, but not certain medically necessary abortions, the fact remains that the Hyde Amendment leaves an indigent woman with at least the same range of choice in deciding whether to obtain a medically necessary abortion as she would have had if Congress had chosen to subsidize no health care costs at all." The Court went on to reject claims based on the free exercise and establishment clauses of the First Amendment, and on the Fifth Amendment guarantee of equal protection. Concluding that to be upheld the funding restriction need only be rationally related to a legitimate State interest, the Court held that the establishment of financial incentives making childbirth "a more attractive alternative" than abortion for Medicaid recipients has a "direct relationship to the legitimate [governmental] interest in protecting potential life."[43]

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[42] *Harris v. McRae*, 448 U.S. 297 (1980).
[43] *Moe v. Sec'y of Admin. & Finance*, 417 N.E.2d 387, 399-400 (Mass. 1981) (internal citations omitted).

The *Moe* court rejected the *Harris v. McRae* rationale pursuant to the privacy clause of the Massachusetts Constitution:

> In our view, "articulating the purpose [of the challenged restriction] as 'encouraging normal childbirth' does not camouflage the simple fact that the purpose, more starkly expressed, is discouraging abortion." As an initial matter, the Legislature need not subsidize any of the costs associated with child bearing, or with health care generally. However, once it chooses to enter the constitutionally protected area of choice, it must do so with genuine indifference. It may not weigh the options open to the pregnant woman by its allocation of public funds; in this area, government is not free to "achieve with carrots what (it) is forbidden to achieve with sticks." We are therefore in agreement with the views expressed by Justice Brennan, writing in dissent to *Harris v. McRae*:
>
> > In every pregnancy, [either medical procedures for its termination, or medical procedures to bring the pregnancy to term are] medically necessary, and the poverty-stricken woman depends on the Medicaid Act to pay for the expenses associated with [those] procedure[s]. But under [this restriction], the Government will fund only those procedures incidental to childbirth. By thus injecting coercive financial incentives favoring childbirth into a decision that is constitutionally guaranteed to be free from governmental intrusion, [this restriction] deprives the indigent woman of her freedom to choose abortion over maternity, thereby impinging on the due process liberty right recognized in *Roe v. Wade.*[44]

This court notes a nuance in the Brennan formulation adopted by Massachusetts. The relevant datum is not a health-endangering condition establishing medical necessity. Rather, the woman's constitutional right to reproductive choice can only be realized with the help of a physician. This need for a physician's participation in an abortion, and not some underlying health problem, defines "medically necessary" in this unique context.

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[44] *Id.* at 402, *citing Harris*, 448 U.S. at 333 (Brennan, J., dissenting).

During the ensuing twenty years after *Harris v. McRae*, fifteen of the twenty states addressing Medicaid abortions under state law aligned with Massachusetts in rejecting the U.S. Supreme Court's holding. In 2001 Alaska became the sixteenth state to do so, joined by Arizona in 2002.[45] Four states (Hawaii, Washington, New York, and Maryland) place no restrictions on Medicaid abortions, without a court order compelling this. The remaining majority of American states follow the federal standard of life endangerment, rape, or incest; although Iowa, Mississippi, and Virginia add fetal impairment.[46]

Our Court's constitutional analysis in *State, DHSS* is very similar to that of the many other courts rejecting a high-risk high-hazard standard and their accompanying approval of virtually unfettered physician discretion. The State's prediction that our Court will now distinguish those other states' holdings and impose a fresh variant of a high-risk high-hazard standard must rest, not on any language found in *State, DHSS*, but on the possibility that the current Court will reconsider the logical implication of that decision.

To illustrate the implausibility of the State's prediction, the court notes that the U.S. Supreme Court in *Harris v. McRae* literally held that discriminatory denial of medically necessary Medicaid abortions constitutes a permissible state-sponsored celebration of potential life. The *State, DHSS* Court definitively rejected this rationale, but without identifying its origin in

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[45] *Simat Corp. v. Ariz. Health Care Cost Containment Sys.*, 56 P.3d 23 (Ariz. 2002).
[46] State Funding of Abortion Under Medicaid, Guttmacher Institute January 1, 2015, appended as Appendix D.

Harris v. McRae. The Court distinguished *Harris v. McRae* in a cursory footnote.[47] Perhaps this led the legislature to credit *Harris v. McRae* as good law. A legislative memo cites *Harris* for the proposition that SB 49 satisfies state equal protection:

> Additionally, the United States Supreme Court, in 1980, ruled that the Hyde Amendment (which is the foundation for SB 49) does not violate women with lower incomes right to obtain a medically necessary abortion. The case was *Harris v. McRae*, 448 US 297 (1980). The State has no obligation to remove obstacles that it did not create (namely the woman's status of being of little means).[48]

Several of the fifteen courts that Alaska joined in rejecting the federal standard afford explicit guidance as to the contours of medical necessity. Because those cases were cited in *State, DHSS*, it is likely that Alaska's Supreme Court will re-examine them closely as it decides whether to itself promulgate a definitive standard.

As noted above, the Massachusetts Supreme Court in *Moe* accepted Justice Brennan's formulation that medical care is always a necessary response to pregnancy, either to terminate or to carry to term. Speaking of an "elective" abortion in isolation from an "elective carriage-to-term" is thus to obscure critical thought; either describes a single choice between mutually exclusive, constitutionally protected options, both equally legitimate in the State's eyes.

The State argues that the *State, DHSS* Court rejected the Brennan approach when it said:

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[47] *State, DHSS*, 28 P.3d at 911 n. 56.
[48] Sen. Coghill Memo to Sen. Fin. Comm. April 1, 2013, appended as Appendix B.

> This case concerns the State's denial of public assistance to eligible women whose health is in danger. It does not concern State payment for elective abortions. . .[49]

But that language may merely allude to the propensity of courts to subdivide complex constitutional issues into discrete sub-topics and to decide only those immediately at hand. For example, the U.S. Supreme Court incrementally held that the Medicaid statute did not require state funding of non-therapeutic abortions in *Beal v. Doe*;[50] validated this statutory construction against constitutional challenge in *Maher*;[51] rejected a due-process challenge to federal and state application of the life endangerment, rape, or incest Hyde standard in *Harris*;[52] and dismissed an equal protection challenge to state and federal Hyde provisions in *Zbaraz*.[53] It took at least four cases to delineate the federal law of Medicaid funding of abortions. It thus remains an open question whether the Alaska Supreme Court would adopt the Brennan-Massachusetts standard; but given the focus in *State, DHSS* on the exclusion from funding of women with discrete health-related conditions, the Court would have to somewhat shift analytical gears to adopt that standard.

Other states mirror Judge Tan's order and simply delegate the medical necessity decision to the unfettered discretion of the physician. The Minnesota formulation disclaims authorizing on-demand Medicaid abortions, even while relegating the decision to a woman's physician:

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[49] *State, Dept. of Health & Social Services v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904, 905 -906 (Alaska 2001)
[50] *Beal v. Doe*, 432 U.S. 454 (1977)
[51] *Maher v. Roe*, 432 U.S. 464 (1977)
[52] *Harris v. McRae*, 448 U.S. 297 (1980).
[53] *Williams v. Zbaraz*, 448 U.S. 358 (1980).

> Contrary to the dissent's allegations, this court's decision will not permit any woman eligible for medical assistance to obtain an abortion "on demand." Rather, under our interpretation of the Minnesota Constitution's guaranteed right to privacy, the difficult decision whether to obtain a therapeutic abortion will not be made by the government, but will be left to the woman and her doctor.[54]

Presumably Minnesota abortion providers are as inclined to discern medical necessity as Alaska ones, who have apparently never failed to do so.

A West Virginia case overturned legislation requiring irreversible loss of a major bodily function in order to justify a Medicaid abortion. The holding reverted West Virginia law to a prior administrative standard that echoed the *Doe v. Bolton* approach and was similar in effect to Judge Tan's formulation:

> For determining whether a submitted medical expense qualifies as medically necessary, the West Virginia Department of Health and Human Services has adopted [a regulation that] provides that the Department:
>
> > makes reimbursement for pregnancy termination when it is determined to be medically advisable by the attending physician in light of physical, emotional, psychological, familial, or age factors (or a combination thereof) relevant to the well-being of the patient.[55]

Thus, a West Virginia physician may consider factors such as youth, pre-existing children, family income, the likelihood of family breakup, domestic violence, and similar stressors that affect a woman's general well-being.

A third iteration of this permissive standard for medical necessity emerges from New Mexico. There, a regulation imposed a life endangerment

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[54] *Women of State of Minn. by Doe v. Gomez*, 542 N.W.2d 17, 32 (Minn. 1995).
[55] *Women's Health Center of West Virginia, Inc. v. Panepinto*, 446 S.E.2d 658, 661 (W. Va. 1993).

standard. The New Mexico Supreme Court reinstated a prior state regulation that more broadly defined medical necessity:

> [A]n abortion is "medically necessary" when a pregnancy aggravates a pre-existing condition, makes treatment of a condition impossible, interferes with or hampers a diagnosis, or has a profound negative impact upon the physical or mental health of an individual.[56]

Although the court did not say so, the conditions of juvenile pregnancy, fetal abnormality, rape, and incest all appear to be reasonably accommodated by the mental health formulation.

The Brennan and Massachusetts standard posits that all abortions are medically necessary. Judge Tan's order, Minnesota, and West Virginia grant unfettered physician discretion. New Mexico broadly guides that discretion. All three approaches arrive at the same outcome. For all practical purposes, they empower a physician to certify virtually any pregnancy as medically necessary within the physician's discretion.

This court's largely undisputed findings of fact indicate that the decision to carry a fetus to term exposes a woman to an inevitable array of foreseeable and unforeseeable risks. A condition as mundane as obesity seriously heightens a woman's pregnancy risk. And all pregnant women face a 30% risk that their pregnancy will terminate in the major surgery of a caesarian delivery. As Dr. Caughey testified, the woman with the lowest statistical pregnancy risk is Caucasian with a normal body-mass ratio, aged 25-29, employed, and with

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[56] *New Mexico Right to Choose/NARAL v. Johnson*, 975 P.2d 841, 844 (N.M. 1998).

access to permanent housing and health insurance. Those qualities are likely not descriptive of many low-income women seeking Medicaid abortions.

Women voluntarily assume the risks of pregnancy in the joyful context of a wanted child. But Alaskan women denied Medicaid abortions by a restrictive standard who are unable to beg, borrow, or earn $650 (or far more for an out-of-state second-trimester abortion) would be forced to carry to term without voluntarily assuming those risks. Meanwhile, Medicaid would expend thirty-two times the $650 cost of their abortion for their prenatal care and delivery expense.

This court concludes no standard that is limited to somatic conditions can be fairly applied to indigent women in all their extraordinary diversity of circumstance, without unjustifiably delaying many abortions until they are riskier, or without imposing an involuntarily assumption of significant risks on those forced by circumstance to carry to term. Doctors routinely consider the life circumstances and mental health of their patients, and abortion-seeking Medicaid patients are entitled to no less quality of care. Once the door is opened to considerations of general physical and mental health as influenced by particular life circumstances, application of any rigid standard becomes wholly impractical. That conclusion belies this court's prediction at the outset of the case that some firm boundary between a medically necessary abortion and an elective abortion would emerge.

The court adopts Judge Tan's formulation of medical necessity as the one most consistent with the rationale and holding of *State, DHSS.* This ruling, if

upheld, means as a practical matter that virtually all indigent Alaskan women seeking abortions will receive state Medicaid funding. Such is consistent with the rights of indigent Alaska women during the last 45 years, and with the rights of indigent women in the sixteen other American states rejecting the federal standard.

V. ORDER

AS 47.07.068 and 7 AAC 160.900(d)(30) violate the equal protection clause of Alaska's Constitution. The court permanently enjoins their enforcement. DHSS will fund all medically necessary Medicaid abortions under the following definition of that term:

> The terms medically necessary abortions or therapeutic abortions are used interchangeably to refer to those abortions certified by a physician as necessary to prevent the death or disability of the woman, or to ameliorate a condition harmful to the woman's physical or psychological health, as determined by the treating physician performing the abortion services in his or her professional judgment.

DATED at Anchorage, Alaska this 27th day of August, 2015.

John Suddock
Superior Court Judge

I certify that on 8-27-15
a copy of the above was mailed
to each of the following at their
addresses of record:

Janet Crepps	*Susan Orlansky*
Laura Einstein	*Stacie Kraly*
Helene Krasnoff	*Autumn Katz*
Julia Kaye	*Brigitte Amiri*
Thomas Stenson	*Margaret Paton-Walsh*

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