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**IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE**

PLANNED PARENTHOOD GREAT
NORTHWEST, HAWAI'I, ALASKA,
INDIANA, AND KENTUCKY,

Plaintiff,

v.

STATE OF ALASKA, et al.,

Defendants.

Case No. _____

**MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFF'S MOTION FOR A
PRELIMINARY INJUNCTION**

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INTRODUCTION

This case challenges a law that requires all Alaskans to travel to a health center in order to receive a medication abortion regardless of their circumstances. The law, for no good reason, delays and denies patients’ access to an essential, constitutionally protected form of health care. The State of Alaska bans the only form of telehealth abortion care that would allow Alaskans to have a medication abortion without traveling to an abortion provider. By requiring all abortions to be provided in a hospital or other health care facility under AS 18.16.010(a)(2), the State prohibits qualified clinicians from providing medication abortions via direct-to-patient (“DTP”) telehealth (the “Telehealth Ban” or the “Ban”), a widely used health care model that allows providers to evaluate and treat a patient via telehealth while the patient is at home or another location of their choosing. The State forces all Alaskans seeking a medication abortion to travel up to hundreds of miles—in some instances more than 700 miles—to visit one of the only two health centers in the state that provide abortions, even though doing so is typically not medically necessary. It is well-documented that such travel distances delay many patients’ access to abortion and prevent some patients from accessing abortion altogether. By imposing these burdens, the Telehealth Ban violates Alaskans’ fundamental right to abortion.

The Telehealth Ban serves no medical purpose. DTP telehealth is a routine, common, and critical mode of delivering many types of health care, including medication abortions. Telehealth is especially important in Alaska, where many people live in rural or remote areas. Indeed, that is why the State otherwise broadly authorizes and encourages the use of DTP telehealth, including for other forms of pregnancy-related care. Yet the

State singles out and prohibits DTP telehealth for abortion—even though providing medication abortions via DTP telehealth is safe and effective, as shown by extensive peer-reviewed medical literature and affirmed by every major medical organization to weigh in on the topic.

Plaintiff Planned Parenthood Great Northwest, Hawai‘i, Alaska, Indiana, and Kentucky (“Planned Parenthood”) seeks a preliminary injunction preventing the State from enforcing this Telehealth Ban, which violates its patients’ rights to privacy and equal protection under the Alaska Constitution. In Alaska, a preliminary injunction is warranted either when: (1) a plaintiff is likely to succeed on the merits of its claims; *or* (2) when the plaintiff faces irreparable harm, the defendant is adequately protected from harm, and the plaintiff’s claims are not frivolous. Although only one of those standards needs to be met to issue a preliminary injunction, Planned Parenthood satisfies both.

Planned Parenthood is likely to succeed on its claim that the Telehealth Ban violates its patients’ right to privacy. The Alaska Supreme Court has repeatedly recognized that the right to privacy in the Alaska Constitution protects the fundamental right to abortion, and that the State cannot burden this fundamental right unless doing so advances a compelling interest by the least restrictive means possible.¹ There is no basis—let alone a compelling one—to restrict abortion access in this manner. Rather than advance Alaskans’ health or safety, the Telehealth Ban *harms* Alaskans by burdening their access to essential care.

¹ See, e.g., *Valley Hosp. Ass’n, Inc. v. Mat-Su Coal. for Choice*, 948 P.2d 963, 969 (Alaska 1997); *State v. Planned Parenthood of the Great Nw.*, 436 P.3d 984, 1001–03 (Alaska 2019) [hereinafter “*Planned Parenthood V*”].

Patients who are delayed or denied in having an abortion due to this Telehealth Ban are left to continue their pregnancies, with all the risks of complications and mortality that doing so brings.

Planned Parenthood is also likely to succeed on its claim that the Telehealth Ban violates its patients' right to equal protection. Alaska's Equal Protection Clause "mandates 'equal treatment of those similarly situated.'"² Without justification, the Telehealth Ban singles out pregnant Alaskans seeking an abortion for this unique and unjustified prohibition while allowing other similarly situated groups to use DTP telehealth to access care, including Alaskans who seek other pregnancy-related care and Alaskans who seek all other types of care for which there is similarly no medical need for an in-person visit.³

The alternative balance-of-hardships standard also warrants a preliminary injunction. In stark contrast with the Telehealth Ban's devastating impact on Alaskans seeking essential health care, the State will face no harm from being unable to enforce a ban that not only fails to further the health of Alaskans but actually harms their health. Nor can the State have any legitimate interest in enforcing an unconstitutional law.

Accordingly, this Court should preliminarily enjoin the State from enforcing the Telehealth Ban.

² *State, Dep't of Health & Soc. Servs. v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904, 909 (Alaska 2001) [hereinafter "*Planned Parenthood I*"] (quoting *Alaska Pac. Assurance Co. v. Brown*, 687 P.2d 264, 271 (Alaska 1984)).

³ Planned Parenthood also challenges the Telehealth Ban as violating its abortion providers' right to equal protection under the Alaska Constitution. Although Planned Parenthood is prepared to litigate that claim, it does not move for a preliminary injunction on that basis.

BACKGROUND

I. Planned Parenthood Provides Sexual & Reproductive Care to Alaskans

Planned Parenthood operates two health centers in Alaska: one in Anchorage and one in Fairbanks.⁴ Planned Parenthood provides a broad range of sexual and reproductive health care services to its patients in Alaska, including well-person exams, birth control, emergency contraception, pregnancy testing and planning, testing and treatment for sexually transmitted infections, miscarriage care, cancer screenings, gender-affirming hormone therapy, certain vaccines, and abortions.⁵

Planned Parenthood's health centers in Anchorage and Fairbanks are the only two publicly identified health centers that provide abortions in the state.⁶ Planned Parenthood provides medication abortions in Alaska through 12 weeks of pregnancy, as measured from the first day of a pregnant person's last menstrual period ("LMP").⁷ Planned Parenthood also provides procedural abortions through 17 weeks and 6 days LMP at its Anchorage health center and through 13 weeks and 6 days LMP at its Fairbanks health center.

Medication abortion, as the name suggests, is a method of terminating a pregnancy by taking one or more medicines in pill form. The majority of abortions Planned Parenthood provides in Alaska are medication abortions.⁸ Planned Parenthood provides medication abortions in Alaska both through in-person care at its Anchorage and Fairbanks

⁴ See Affidavit of Colleen P. McNicholas, DO, MSCI, FACOG ¶ 11 ["McNicholas Aff."].

⁵ See *id.*

⁶ See *id.* ¶ 34.

⁷ See *id.* ¶ 14.

⁸ See *id.* ¶ 18.

health centers and through site-to-site telehealth, a more limited form of telehealth in which a patient travels to a Planned Parenthood health center and, while there, connects via telehealth with an abortion provider in a different location.⁹ Although site-to-site telehealth improves access for patients when the nearest Planned Parenthood health center does not have an abortion provider present on a given day, this model is often inaccessible to the many Alaskans who face barriers to traveling to either health center.¹⁰

Planned Parenthood offers many of its health care services through DTP telehealth in Alaska, including birth control, emergency contraception, gender-affirming hormone therapy, HIV services, pregnancy testing and planning, care for other sexual and reproductive health concerns, and some gynecological consults, such as consults for chronic pelvic pain and recurrent or persistent cervical dysplasia.¹¹

II. Abortions Are Safe, Effective, and Essential Health Care

Abortion is a common form of essential health care. In the United States, an estimated one in four women of reproductive age will have an abortion by the time she reaches the age of forty-five.¹² As of 2020, the most recent year for which data are available, nearly one in five pregnancies in the United States ended in abortion.¹³ Patients decide to have abortions for a variety of reasons, including familial, medical, financial, and personal ones. For example, some decide that it is not the right time to have a child or add

⁹ *See id.* ¶¶ 16–17.

¹⁰ *See id.* ¶ 17.

¹¹ *See id.* ¶ 12.

¹² *See* Affidavit of Daniel Grossman, M.D. ¶ 11 [hereinafter “Grossman Aff.”].

¹³ *See id.*

to their families; some end a pregnancy because of a severe fetal anomaly; some choose not to carry a pregnancy to term because they have become pregnant as a result of rape or incest; some choose not to have biological children; and for some, continuing with a pregnancy would pose a significant risk to their health.¹⁴

Every major medical organization to weigh in on the topic has concluded that abortion is a safe, common, and essential form of health care, including the American Medical Association,¹⁵ World Health Organization,¹⁶ American College of Obstetricians & Gynecologists (“ACOG”),¹⁷ Royal College of Obstetricians & Gynaecologists,¹⁸ Society for Maternal-Fetal Medicine,¹⁹ and the Society of Family Planning.²⁰ In fact, abortions are markedly safer than carrying a pregnancy to term and giving birth.²¹

¹⁴ See *id.* ¶ 12; Verified Compl. ¶ 29.

¹⁵ See AMA Code of Med. Ethics, *Opinion 4.2.7: Abortion*, <https://code-medical-ethics.ama-assn.org/ethics-opinions/abortion> (last visited June 2, 2026).

¹⁶ See World Health Org., *Abortion*, <https://www.who.int/news-room/fact-sheets/detail/abortion> (last visited June 2, 2026).

¹⁷ See ACOG, *Abortion Access Fact Sheet*, <https://www.acog.org/advocacy/abortion-is-essential/come-prepared/abortion-access-fact-sheet> (last visited June 2, 2026).

¹⁸ See Royal Coll. Obstetricians & Gynaecologists, *Abortion Care Is Healthcare*, <https://www.rcog.org.uk/about-us/global-network/centre-for-womens-global-health/contraception-and-abortion/our-making-abortion-safe-programme/key-messages-on-safe-abortion/abortion-care-is-healthcare/> (last visited June 2, 2026).

¹⁹ See Soc’y Maternal-Fetal Med. et al., *Society for Maternal-Fetal Medicine Position Statement: Access to Abortion Care B7* (July 2024), https://assets.noviams.com/novi-file-uploads/smfm/Publications_and_Guidelines/Position_Statements/Society_for_Maternal_Fetal_Medicine_Position_Statement_Access_to_abortion_care.pdf.

²⁰ See Soc’y Fam. Planning, *Society of Family Planning Position Statement: Abortion Is Essential Healthcare* (2025), <https://societyfp.org/wp-content/uploads/2025/07/Abortion-is-essential-healthcare.pdf>.

²¹ See Grossman Aff. ¶ 33.

During the first trimester of pregnancy, a patient seeking an abortion can have either a medication abortion or a procedural abortion. This case concerns medication abortion, the most common abortion method in the United States.²² Evidence-based research and practice have shown that medication abortion is safe and effective through at least 12 weeks LMP.²³

There are multiple medication abortion regimens.²⁴ The regimen most commonly used in the United States includes two medications: mifepristone and misoprostol.²⁵ In this regimen, a patient first takes mifepristone, a medication that temporarily blocks the hormone progesterone, which is necessary to maintain pregnancy.²⁶ A patient then takes misoprostol up to seventy-two hours after mifepristone, which causes the uterus to contract and expel its contents.²⁷ Another regimen uses solely misoprostol, which, as in the mifepristone/misoprostol regimen, causes the uterus to contract and expel the pregnancy.²⁸ In either regimen, a patient passes the pregnancy in a manner similar to miscarriage.²⁹ Mifepristone and misoprostol are both also commonly used to help patients who are experiencing a miscarriage pass the pregnancy.³⁰

²² *See id.* ¶ 17.

²³ *See id.* ¶ 14.

²⁴ *See id.*; McNicholas Aff. ¶ 13.

²⁵ *See* Grossman Aff. ¶ 14; McNicholas Aff. ¶ 13.

²⁶ *See* Grossman Aff. ¶ 14; McNicholas Aff. ¶ 13.

²⁷ *See* Grossman Aff. ¶ 14; McNicholas Aff. ¶ 13.

²⁸ *See* Grossman Aff. ¶ 14; McNicholas Aff. ¶ 13.

²⁹ *See* McNicholas Aff. ¶ 13.

³⁰ *See* Grossman Aff. ¶¶ 15, 31; McNicholas Aff. ¶ 13.

Medication abortions are safe and effective.³¹ The National Academies, a nongovernmental institution established by congressional charter in 1863 that “bring[s] together the nation’s leading experts through rigorous, evidence-based processes to deliver high-quality, independent advice,”³² conducted a comprehensive review of the science of abortion and found that complications following medication abortions are rare.³³ ACOG, the leading professional organization of OB/GYNs in the United States, has similarly explained that medication abortion “is a safe and effective method of providing abortion.”³⁴

Abortion is time-sensitive health care.³⁵ Although abortion is safe throughout pregnancy, the risk of complications from an abortion increases incrementally as pregnancy progresses.³⁶ Patients who have an abortion later in pregnancy due to delays in accessing care thus face a higher risk of abortion-related complications than if they had been able to have an abortion earlier in pregnancy. Additionally, patients who are delayed in having an abortion, and who are thus forced to stay pregnant longer, face a greater risk

³¹ See Grossman Aff. ¶ 14; McNicholas Aff. ¶ 13.

³² Nat’l Acads. of Scis., Eng’g, & Med., *Process*, <https://www.nationalacademies.org/index.php/process> (last visited June 2, 2026).

³³ See, e.g., Nat’l Acads. of Scis., Eng’g, & Med., *The Safety and Quality of Abortion Care in the United States* 55 (2018) [hereinafter “*National Academies Report*”].

³⁴ ACOG, *Practice Bulletin No. 225: Medication Abortion Up to 70 Days of Gestation*, 136 *Obstetrics & Gynecology* e31, e31, e35 (2020) [hereinafter “*ACOG, Practice Bulletin No. 225*”].

³⁵ See Grossman Aff. ¶¶ 32, 57; cf. *Planned Parenthood of the Great Nw. v. State*, 375 P.3d 1122, 1141 (Alaska 2016) [hereinafter “*Planned Parenthood IV*”] (noting that, “because the superior court found that in Alaska an abortion generally is unavailable after about 14 weeks’ gestation, time is of the essence”).

³⁶ See Grossman Aff. ¶¶ 32, 57.

of pregnancy-related complications than if they had been able to have an abortion earlier in pregnancy.³⁷

People who seek an abortion and are denied access to care are forced to carry their pregnancies to term. It is well-established that abortion is safer than continuing a pregnancy to term and giving birth.³⁸ As a result, people who are denied a wanted abortion risk a range of serious adverse health outcomes that pregnant people face throughout pregnancy and childbirth, including but not limited to exposure to risks of major complications and death.³⁹ These risks fall disproportionately on Alaska Native and Black women and rural residents, who have higher pregnancy-related morbidity and mortality rates.⁴⁰

III. Providing Medication Abortions via Direct-to-Patient Telehealth Expands Access and Is Safe and Effective

Telehealth is a vital part of the health care system in Alaska and in the United States more broadly. Telehealth significantly expands access to health care, particularly for patients who otherwise would face difficulty accessing in-person care.⁴¹ This includes patients in rural areas and other areas with provider shortages, where physicians (including specialists) or other clinicians are not always readily available or present at all.⁴² Being able to access health care via telehealth is particularly vital in Alaska, where many

³⁷ *See id.* ¶ 66.

³⁸ *See id.* ¶ 33.

³⁹ *See id.* ¶¶ 34–36.

⁴⁰ *See* McNicholas Aff. ¶ 37; Grossman Aff. ¶ 33.

⁴¹ *See* Grossman Aff. ¶ 37.

⁴² *See id.*

Alaskans live in rural or remote areas, including in communities that are inaccessible by road.⁴³

Telehealth has been used to help Alaskans access care for more than fifty years.⁴⁴ The Alaska Federal Health Care Access Network has used telehealth for decades to improve access to care for Alaskans, allowing providers to “connect[] to a vast network of providers and specialists” outside of their communities, including for obstetric and gynecological care.⁴⁵ As the Alaska Native Tribal Health Consortium recognizes, “[t]elehealth has changed the face of medicine” in Alaska, allowing providers to care for their patients “when they need to be seen, not only when the weather cooperates.”⁴⁶

⁴³ As this Court well knows, Alaska has the largest geographic size and is the least densely populated of any state in the country, and many Alaskans live in rural areas. *See* America Counts Staff, *Alaska, Least Densely Populated State, Had Population of 733,391 in 2020*, U.S. Census Bureau (Aug. 25, 2021), <https://www.census.gov/library/stories/state-by-state/alaska.html>; Am.’s Health Rankings, *Rural Population in Alaska*, https://www.americashealthrankings.org/explore/measures/pct_rural_b/AK#measure-trend-summary (last visited June 3, 2026). As of 2023, the Alaska Department of Transportation and Public Facilities reported that 82% of communities and Federal Aviation Administration-recognized locations in Alaska could not be accessed by road. *See* Alaska Dep’t Transp. & Pub. Facilities, *Department Fast Facts: Prepared for Legislative Session 2023 8* (2023). And as one 2021 study notes, “more than 60,000 people liv[e] in remote communities of fewer than 1000 residents that are located off the road system and are only accessible by plane or boat.” *See* Laura Eichelberger et al., *Implications of Inadequate Water and Sanitation Infrastructure for Community Spread of COVID-19 in Remote Alaskan Communities*, 776 *Sci. Total Env.* 1, 3 (2021).

⁴⁴ Heather E. Hudson, *Perspective: Rural Telemedicine: Lessons from Alaska for Developing Regions*, 11 *Telemedicine & e-Health* 460, 462 (2005).

⁴⁵ Alaska Native Tribal Health Consortium, *Telehealth—for Providers*, <https://anthc.org/education-training/provider-telehealth/> (last visited June, 3 2026).

⁴⁶ *Id.*

Medication abortions are commonly provided via telehealth in the United States. The most widely used form of telehealth abortion care uses a telehealth model called DTP telehealth. Providing medication abortions via DTP telehealth is authorized by state law in twenty-five states and in the District of Columbia.⁴⁷ Planned Parenthood already provides medication abortions via DTP telehealth to its eligible patients in Hawai‘i and Washington.⁴⁸

To have a medication abortion via DTP telehealth, a patient can be in their home or another location of their choosing.⁴⁹ An abortion provider in a different location uses telehealth technologies to evaluate whether a patient is eligible for a medication abortion.⁵⁰ To determine eligibility, providers evaluate detailed information about the patient’s medical history and any symptoms they may be having.⁵¹ This includes the use of screening protocols to calculate the duration of the pregnancy and assess whether the patient has risk factors for or symptoms of an ectopic pregnancy, two key factors that determine whether a

⁴⁷ KFF, *Abortion in the United States Dashboard*, <https://www.kff.org/womens-health-policy/abortion-in-the-u-s-dashboard/> (last visited June 3, 2026).

⁴⁸ *See* McNicholas Aff. ¶ 27.

⁴⁹ *See id.* ¶ 9; Grossman Aff. ¶ 7.

⁵⁰ *See* McNicholas Aff. ¶ 21; Grossman Aff. ¶ 46.

⁵¹ *See* McNicholas Aff. ¶ 21; Grossman Aff. ¶ 46.

patient is eligible for a medication abortion.⁵² If eligible, the patient is sent the abortion medications by mail or common carrier.⁵³

Although some patients have an ultrasound before their abortion, it is typically not medically necessary for a patient to have an ultrasound or other physical testing before a medication abortion. It is well-documented that, by using the above-referenced screening protocols, providers can identify the small number of patients for whom an ultrasound or other in-person screening is medically indicated, including, for example, because a patient is having symptoms that indicate a potential ectopic pregnancy.⁵⁴ In fact, even patients who do visit a health center for a medication abortion can forgo an ultrasound if the same evidence-based screening protocols determine that one is not necessary.⁵⁵ If the provider determines that a DTP telehealth patient should have an ultrasound before their abortion—including because there is insufficient information to assess the duration of the pregnancy otherwise or because there are risk factors for or symptoms of an ectopic pregnancy—

⁵² See McNicholas Aff. ¶ 21; Grossman Aff. ¶ 46. An ectopic pregnancy is a condition in which a fertilized egg implants and grows outside the uterus. See Grossman Aff. ¶ 46 fn. 85. While the above-referenced protocols sufficiently screen patients for the potential of an ectopic pregnancy, in the rare event that a patient with an ectopic pregnancy takes abortion medication, early access to medication abortion can actually facilitate timely detection of an ectopic pregnancy because patients with an ectopic pregnancy will not experience the expected effects of the medications and will be instructed to seek follow-up care. However, because it is important to detect and treat ectopic pregnancies as early as possible and because a medication abortion using a mifepristone/misoprostol or misoprostol-only regimen does not terminate an ectopic pregnancy, providers screen for the possibility of this condition at the outset regardless of whether the patient seeks their abortion care in person or via DTP telehealth. See *id.*

⁵³ See Verified Compl. ¶ 46.

⁵⁴ See McNicholas Aff. ¶¶ 21–23; Grossman Aff. ¶¶ 46–48.

⁵⁵ See McNicholas Aff. ¶ 21; Grossman Aff. ¶ 42.

Planned Parenthood requires the patient to have an ultrasound.⁵⁶ As with all abortion patients, patients who have a medication abortion via DTP telehealth give informed consent to the care. As part of this informed consent process, patients receive detailed information on when and how to take the medication, what to expect and what to do if they have questions or concerns, and potential side effects and complications.⁵⁷

Like in-person medication abortions, medication abortions provided via DTP telehealth are safe and effective.⁵⁸ Studies confirm that when provided via DTP telehealth, medication abortions have high rates of efficacy and very low complication rates.⁵⁹ Even for patients who visit a health center for a medication abortion, any complications would not occur until a patient has already left the health center.⁶⁰ There is thus no medical benefit to forcing patients to travel to a health center to have a medication abortion.⁶¹

Relying on peer-reviewed research, major medical organizations have endorsed the safety and efficacy of providing medication abortions via DTP telehealth. ACOG explains that “[m]edication abortion can be provided safely and effectively by telemedicine with a high level of patient satisfaction,” and that “[m]edication abortion through telemedicine has been evaluated in observational studies and found to be equally effective as an in-

⁵⁶ See McNicholas Aff. ¶ 22; Verified Compl. ¶ 49.

⁵⁷ See McNicholas Aff. ¶ 27.

⁵⁸ See Grossman Aff. ¶¶ 41–43, 47–48; McNicholas Aff. ¶¶ 19–25, 27.

⁵⁹ See McNicholas Aff. ¶ 24; Grossman Aff. ¶¶ 47–48.

⁶⁰ See McNicholas Aff. ¶ 25; Grossman Aff. ¶¶ 29, 42.

⁶¹ See McNicholas Aff. ¶ 25.

person visit.”⁶² ACOG notes that an analysis of nearly 20,000 medication abortions found that “adverse events were rare (0.3% overall) and did not differ between those who choose telemedicine or in-person services.”⁶³ The Society of Family Planning, the leading membership organization for family planning clinicians in the United States, notes that providing medication abortions via DTP telehealth has become “the prevailing telehealth abortion care model” and that “[r]esearch has demonstrated that the safety and effectiveness of telehealth medication abortion care is comparable to in-clinic medication abortion care models.”⁶⁴ The World Health Organization similarly recommends DTP telehealth as an option for delivering abortion care based on a systematic review of studies.⁶⁵ The Society for Maternal-Fetal Medicine notes that “[a]bortion care is commonly and increasingly occurring outside of traditional clinical settings,” including through DTP telehealth; it “supports access to abortion without unnecessary barriers, including via telemedicine abortion care.”⁶⁶ The National Abortion Federation, which develops clinical guidelines for independent abortion providers, also explains that “[t]elemedicine can be

⁶² ACOG, *Practice Bulletin No. 225*, *supra* note 34, at e35 (citing study on the use of DTP telehealth for medication abortions).

⁶³ *Id.*

⁶⁴ Soc’y Fam. Planning, *Science Says: Telehealth Medication Abortion Care Is Safe and Effective* 1, 2 (Sept. 6, 2023), https://societyfp.org/wp-content/uploads/2023/09/SFP_ScienceSays_Template-TelehealthMedicationAbortion-f.pdf.

⁶⁵ World Health Org., *Abortion Care Guideline* 95 (2022), <https://iris.who.int/server/api/core/bitstreams/59a704cc-4024-412a-97d9-55d86d139602/content>.

⁶⁶ Soc’y Maternal-Fetal Med. et al., *Society for Maternal-Fetal Medicine Statement: RhD Immune Globulin After Spontaneous or Induced Abortion at Less Than 12 Weeks of Gestation*, 230 *Am. J. Obstetrics & Gynecology* B2 (2024).

safely used to provide abortion care, including medication abortion provision, informed consent, and follow-up,” and that, “[f]or most patients, testing before a medication abortion, including ultrasound, is not required.”⁶⁷

As part of Planned Parenthood’s informed consent process, all patients to whom it provides a medication abortion via DTP telehealth (which is only in the states where it operates in which that care is currently legal) receive information about what to expect, including about how to understand whether the symptoms they experience after taking abortion medication are normal or could be a cause for concern—just like patients having a medication abortion in person.⁶⁸ Planned Parenthood’s abortion patients are also given access to a 24/7 triage line staffed by health care providers.⁶⁹ If a patient experiences any symptoms that raise concerns, the patient can call the triage line to speak with a health care provider, regardless of whether their initial visit was conducted in person.⁷⁰ If a patient needs to seek additional care following a medication abortion, such care can often be provided through DTP telehealth, including by prescribing additional doses of misoprostol to help empty the uterus.⁷¹ If a patient does need in-person follow-up care, they could visit a Planned Parenthood health center or a local provider.⁷²

⁶⁷ Nat’l Abortion Fed., *Clinical Policy Guidelines for Abortion Care 2026* 1, 21 (2026).

⁶⁸ *See* McNicholas Aff. ¶ 27.

⁶⁹ *See id.*

⁷⁰ *See id.*

⁷¹ *See id.*

⁷² *See id.*

In states where Planned Parenthood already provides medication abortions via DTP telehealth, its protocols account for any delays inherent in the process of mailing medications.⁷³ Although medication abortions are safe and effective through at least 12 weeks LMP, when Planned Parenthood provides medication abortions via DTP telehealth to patients in Hawai‘i and Washington, the medications are currently sent only to patients whose pregnancy duration is up to 11 weeks and 3 days LMP to account for the time it takes the medications to arrive.⁷⁴ The medications are typically shipped via FedEx two-day shipping.⁷⁵

IV. The State Bans Providing Medication Abortions Via Direct-to-Patient Telehealth

The State broadly authorizes and encourages the use of DTP telehealth, including to provide pregnancy-related care, with one exception: it bans the use of DTP telehealth to provide medication abortions. By requiring all abortions to be provided in a hospital or other health care facility under AS 18.16.010(a)(2), the State singles out abortion for differential treatment, preventing Alaskans from accessing abortion care via a safe, effective, and common telehealth model. But for this Telehealth Ban, Planned Parenthood would provide medication abortions via DTP telehealth to its patients in Alaska.⁷⁶

With the exception of abortion, the State allows Alaska-licensed providers to use telehealth—including DTP telehealth—to offer any care within their scope of practice,

⁷³ *See id.* ¶ 28.

⁷⁴ *See id.*

⁷⁵ *See id.*

⁷⁶ *See id.* ¶ 9.

without requiring the provider to have first seen the patient in person.⁷⁷ It prohibits the Department of Health and licensing boards from limiting the physical setting in which a provider can be located while providing care via telehealth.⁷⁸ The State also generally allows providers to prescribe and dispense medications via telehealth, including controlled substances under certain circumstances. For instance, Alaska law allows providers to use DTP telehealth to prescribe Schedule IA substances, which “have the highest degree of danger or probable danger to a person or the public,” such as codeine, morphine, and gamma-hydroxybutyric acid (GHB), and Schedule IIA substances such as amphetamines, pentobarbital, psilocybin, and peyote.⁷⁹ The State does not prohibit clinicians from providing any other pregnancy-related care besides abortion via DTP telehealth.

Despite this broad authorization of DTP telehealth, the State prohibits clinicians from using DTP telehealth to provide medication abortions. Under AS 18.16.010(a)(2), “[a]n abortion may not be performed in this state unless . . . the abortion is performed in a hospital or other facility approved for the purpose by the Department of Health or a hospital

⁷⁷ AS 08.02.130(a); *see also* AS 08.02.130(h) (stating that providers do not need to document that there was a barrier to in-person visits before providing a service via telehealth).

⁷⁸ AS 08.02.130(h).

⁷⁹ *See* AS 08.02.130(e)–(f) (noting that physicians, physician assistants, and advanced practice registered nurses can “prescribe, dispense, or administer through telehealth . . . a prescription for a controlled substance listed in AS 11.71.140–11.71.190” if the provider “complies with state and federal law governing the prescription, dispensing, or administering of a controlled substance”); AS 08.64.364(a)–(b) (explaining conditions under which a physician or physician assistant can prescribe, dispense, or administer a controlled substance without conducting a physical examination); AS 11.71.140 (listing Schedule IA controlled substances); AS 11.71.150 (listing Schedule IIA controlled substances).

operated by the federal government or an agency of the federal government.” In a 2023 press release that remains publicly available on the Alaska Department of Law’s official website, Alaska’s then-Attorney General appears to have taken the position that this statute bans providing medication abortions via DTP telehealth. Without explicitly citing AS 18.16.010(a)(2), he stated that “[u]nder Alaska law, a woman in Alaska who receives a dose of mifepristone does so in a clinical setting” and that “no matter what, the pill is still administered in a clinic,” with the prescribing provider either physically present or present via site-to-site telehealth.⁸⁰ Anyone “who knowingly violates” AS 18.16.010(a)(2) commits a felony, punishable by “a fine of not more than \$1,000, or by imprisonment for not more than five years, or by both.”⁸¹

⁸⁰ Alaska Dep’t of Law, *Press Release: Clarity on Alaska Law and Mifepristone* (Mar. 17, 2023), <https://law.alaska.gov/press/releases/2023/031723-Mifepristone.html> [hereinafter “AG Press Release”].

The same press release further addressed the then-Attorney General’s view that pharmacies could not dispense mifepristone based on a different statutory provision, AS 18.16.010(a)(1), which states that “[a]n abortion may not be performed in this state unless . . . the abortion is performed by a physician licensed by the State Medical Board under AS 08.64.200.” *See id.* On this point, the AG Press Release states that “AS 18.16.010(a)(1) has always operated to prohibit the *sale* of mifepristone directly to patients, whether by mail or in person.” *Id.* (emphasis added). Planned Parenthood does not understand AS 18.16.010(a)(1) to independently prohibit clinicians from providing medication abortions via DTP telehealth. Putting aside that this aspect of the AG Press Release has no application to the provision of abortion by licensed medical practitioners (as opposed to pharmacists who sell mifepristone), the plain language of AS 18.16.010(a)(1) clearly does not prohibit how or where a medication abortion can be provided; rather, it only purports to limit who can provide them. However, to the extent the State interprets AS 18.16.010(a)(1) to somehow also prohibit licensed clinicians from providing medication abortions via DTP telehealth, Planned Parenthood also challenges any such interpretation of AS 18.16.010(a)(1) as unlawful, and in the alternative, challenges AS 18.16.010(a)(1) as violating its patients’ right to privacy and equal protection if it is so interpreted.

⁸¹ AS 18.16.010(c).

Another statute that cross-references AS 18.16.010(a)(2) sheds light on the degree to which the State singularly excludes abortion care from its broad authorization of DTP telehealth. AS 08.64.364 outlines the circumstances under which physicians and physician assistants are authorized to diagnose and treat patients and prescribe medications—including controlled substances—without conducting a physical examination.⁸² But AS 08.64.364 provides that, notwithstanding that authorization, clinicians cannot provide medication abortions unless they comply with AS 18.16.010.⁸³

V. The Telehealth Ban Burdens Alaskans' Abortion Access

The Telehealth Ban burdens Alaskans' abortion access. Many people face barriers to traveling to a health center that provides abortions. This is particularly true in Alaska, where many Alaskans can travel to Anchorage or Fairbanks only by plane and where even some of those who can reach Anchorage or Fairbanks by car have to travel hundreds of miles to do so—in some instances more than 700 miles. The Telehealth Ban thus often forces Alaskans who face barriers to traveling to a health center to either delay having an

⁸² By contrast, a Medical Board regulation states that an abortion “patient shall be examined by a physician licensed in this state, and a written record of the patient’s physical and emotional health shall be prepared before performing an abortion.” 12 AAC 40.080. Notably, this provision does not require an in-person examination and thus Planned Parenthood does not understand this regulation to independently prohibit medication abortions via DTP telehealth, but rather to allow for examinations using telehealth technologies to evaluate a patient’s eligibility for medication abortion based in part on reported medical history, symptoms, and/or other data. However, to the extent that the State may disagree with this interpretation, Planned Parenthood also challenges 12 AAC 40.080 as violating its patients’ right to privacy and equal protection under the Alaska Constitution.

⁸³ AS 08.64.364(c)(1).

abortion or be denied an abortion altogether, left to continue carrying their pregnancies with all the medical risks that doing so brings.

People face barriers to traveling to a health center to seek abortions for a variety of reasons. Most abortion patients have already previously given birth,⁸⁴ and those who are parents often have to arrange childcare coverage in order to travel. Some patients have mobility limitations or other disabilities that make travel difficult.⁸⁵ Most patients seeking abortions are below 200% of the federal poverty line; if the patient does not live close to a health center, travel to a center can be prohibitively expensive.⁸⁶ Some patients work low-wage jobs with limited or no paid sick leave and limited scheduling flexibility.⁸⁷ Patients with low incomes also often face transportation limitations such as lacking a car.⁸⁸ The Telehealth Ban makes it significantly more difficult for patients experiencing these barriers to access abortions.

Many abortion patients are also at risk of or experience intimate partner violence. Alaska has some of the highest rates in the nation of women's lifetime prevalence of intimate partner violence.⁸⁹ According to the 2020 Alaska Victimization Survey, 69.6% of

⁸⁴ See Grossman Aff. ¶ 12.

⁸⁵ See McNicholas Aff. ¶ 30.

⁸⁶ See Grossman Aff. ¶ 65.

⁸⁷ See *id.*

⁸⁸ See *id.* ¶¶ 61, 65.

⁸⁹ See Hui Zhang Kudon et al., *The National Intimate Partner and Sexual Violence Survey: 2023/2024 Intimate Partner Violence Data Brief*, Ctrs. Disease Control & Prevention (2026) (noting that Alaska has a weighted 47.1% rate of women's lifetime prevalence of any contact sexual violence, physical violence, and/or stalking by an intimate partner (the third highest in the nation) and a weighted 50.2% rate of women's lifetime prevalence of psychological aggression by an intimate partner (the highest in the nation)).

Alaskan women had experienced intimate partner abuse (including psychological aggression, coercive control and entrapment, and/or physical violence) during their lifetime, and 19.9% had during the prior year.⁹⁰ As of 2024, the reported rate of rape and attempted rape in Alaska was more than three times as high as the national average.⁹¹ In general, rates of intimate partner violence are higher during pregnancy and among people seeking an abortion.⁹² Some abusive partners try to coerce their victims into becoming or staying pregnant as a means of control,⁹³ and some survivors seek to end their pregnancy so that they and/or their family can escape an abusive partner.⁹⁴ People who are at risk of or experiencing intimate partner violence often urgently need to keep their decision to have an abortion confidential to avoid increasing the risk of violence.⁹⁵ By requiring them to travel to a health center for care that they could otherwise have safely had in their home or another location of their choosing, the Telehealth Ban jeopardizes the confidentiality of

⁹⁰ See Univ. of Alaska Anchorage, *Detailed Intimate Partner Abuse Results*, <https://www.uaa.alaska.edu/academics/college-of-health/departments/school-of-justice-and-human-services/justice-center/avs/avs-results/intimate-partner-abuse-results.cshtml> (last visited June 3, 2026).

⁹¹ Univ. of Alaska Anchorage, *Sexual Assault in Alaska: Fact Sheet and Resources*, https://www.uaa.alaska.edu/about/university-advancement/umac//media-room/uaa-media-releases/2016/_documents/20160322-UAA-Stalking-Bogeyman-FS.pdf (last visited June 3, 2026) (“Alaska has the most rapes per capita of any state, averaging 105 rapes per 100,000 inhabitants, nearly three times the national average.”).

⁹² See Grossman Aff. ¶ 71.

⁹³ See *id.*

⁹⁴ See *id.*

⁹⁵ See McNicholas Aff. ¶ 33.

their care, exposing them to a risk of violence and potentially depriving them of care altogether.⁹⁶

The above-described barriers are exacerbated in Alaska, where Alaskans must often travel significantly farther distances to reach a health center that provides abortions, sometimes under conditions that are particularly challenging or impossible. Alaska has an acute shortage of abortion providers. As noted above, Planned Parenthood operates the only two publicly identified health centers that provide abortions in the state, in Anchorage and Fairbanks.⁹⁷ Based on July 2025 population estimates published by the Alaska Department of Labor and Workforce Development, 93.3% of Alaska’s boroughs and census areas lack a health center that provides abortions, and 44.7% of women aged 15–44 in Alaska live in one of those boroughs or census areas.⁹⁸ By preventing Alaskans from having a medication abortion via DTP telehealth, the Telehealth Ban forces patients to travel often long distances to the nearest health center that provides abortions. In 2025, Planned Parenthood provided medication abortions to patients who reported residences in Alaska as far as hundreds of miles away from the health center at which they sought care—including more than 700 miles away.⁹⁹ From some communities in Alaska where Planned Parenthood’s patients reside, it is not possible to travel by car to Anchorage or Fairbanks, and patients must instead travel by plane.¹⁰⁰

⁹⁶ *See id.*; Grossman Aff. ¶ 71.

⁹⁷ *See* McNicholas Aff. ¶¶ 11, 34.

⁹⁸ *See id.* ¶ 34.

⁹⁹ *See id.* ¶ 35.

¹⁰⁰ *See id.*

For some Alaskans, the barriers to traveling to a health center are insurmountable. These patients are forced to remain pregnant against their will, with all the medical risks that doing so brings.¹⁰¹ For patients who are able to travel to a health center, the Telehealth Ban nonetheless often causes significant delays in accessing care, which can prevent some patients from having a medication abortion. Some patients are close to 12 weeks LMP by the time they are able to make an appointment. For these patients, being able to access timely care can mean the difference between being able to choose to have a medication abortion and only having the option of a procedural abortion. Because medication abortions are currently available in Alaska only through 12 weeks LMP, delays in access mean that some patients lose the ability to have a medication abortion even though that may be the best abortion care option for them.¹⁰²

Some patients have medical conditions or other indications that, when considering all of the relevant factors, make a medication abortion the preferred approach.¹⁰³ Patients

¹⁰¹ See Grossman Aff. ¶¶ 33, 52, 69.

¹⁰² See, e.g., “It Just Seemed Like a Perfect Storm”: A Multi-Methods Feasibility Study on the Use of Facebook, Google Ads, and Reddit to Collect Data on Abortion-Seeking Experiences from People Who Considered But Did Not Obtain Abortion Care in the United States, 17 PLoS ONE 1, 11 (2022) (in a study of people who had considered an abortion but not obtained one or visited an abortion clinic, finding that “[s]ome respondents stated that medication abortion was the only acceptable method of abortion for them”).

¹⁰³ See McNicholas Aff. ¶ 36; ACOG, *Practice Bulletin No. 225*, *supra* note 34, at e32 (“There are medical conditions for which a medication abortion may be preferable to uterine aspiration. Such examples include uterine fibroids that significantly distort the cervical canal or uterine cavity, congenital uterine anomalies, or introital scarring related to infibulation.” (footnotes omitted)).

also often have a strong preference for a medication abortion over a procedural abortion.¹⁰⁴ Such a preference often arises because patients feel safer and more comfortable passing a pregnancy in the privacy of their own homes or because they want to avoid gynecological procedures in which instruments are inserted into their vagina and uterus, including because of past sexual, medical, or other physical traumas.¹⁰⁵ For some patients at risk of or experiencing intimate partner violence, access to medication abortion increases their safety because it allows them to end their pregnancy without their partner’s knowledge.¹⁰⁶

Procedural abortions after 12 weeks LMP are also more costly than medication abortions, which prevents some Alaskans from accessing care if they are forced to delay until after the time when a medication abortion is available.¹⁰⁷ According to the State’s most recent annual report on abortion statistics, more than a third of abortions in 2025 in Alaska were paid for out of pocket.¹⁰⁸

For patients who are ultimately able to have an abortion, the Telehealth Ban increases patients’ risk of abortion-related complications by subjecting them to delays and thus causing them to have abortions later in pregnancy. Although abortion is safe

¹⁰⁴ See, e.g., Jane W. Seymour et al., *What Attributes of Abortion Care Affect People’s Decision-Making? Results from a Discrete Choice Experiment*, 131 *Contraception* 1, 4 (2024) (in a survey, finding that “most respondents (58.7%) either slightly (21.6%) or strongly (37.1%) preferred medication abortion”).

¹⁰⁵ See Grossman Aff. ¶ 50.

¹⁰⁶ See *id.* ¶ 71; McNicholas Aff. ¶ 33.

¹⁰⁷ See Verified Compl. ¶ 76.

¹⁰⁸ Alaska Dep’t of Health, *Alaska Induced Terminations 2025 Annual Report* 16, <https://health.alaska.gov/media/sohdqwnb/2025-alaska-induced-terminations-annual-report.pdf> (last updated Feb. 10, 2026).

throughout pregnancy, the risk of complications increases incrementally as pregnancy progresses.¹⁰⁹ Patients who are delayed or denied access to an abortion due to the Telehealth Ban also face increased risks of pregnancy complications.¹¹⁰ Those who are delayed in seeking abortions or forced to forgo care altogether thus face additional risks in having to continue their pregnancies. These burdens fall disproportionately on Alaska Native and Black women and people living in rural areas, who have higher pregnancy-related morbidity and mortality rates.¹¹¹

ARGUMENT

I. STANDARDS FOR GRANTING A PRELIMINARY INJUNCTION

Under Alaska law, a court may grant a preliminary injunction if a plaintiff has met either of two standards: the probable-success-on-the-merits standard or the balance-of-hardships standard.¹¹² Under the probable-success-on-the-merits standard, a preliminary injunction is warranted if a plaintiff has made “a clear showing of probable success on the merits.”¹¹³ Under the balance-of-hardships standard, a preliminary injunction is warranted where: (1) the plaintiff faces irreparable harm if the challenged law is not enjoined; (2) the opposing party would be “adequately protected” from harm if the injunction were granted; and (3) the plaintiff has “raise[d] serious and substantial questions going to the merits of

¹⁰⁹ See *National Academies Report*, *supra* note 33, at 10.

¹¹⁰ See McNicholas Aff. ¶¶ 29, 37; Grossman Aff. ¶¶ 33, 52, 57, 69.

¹¹¹ See McNicholas Aff. ¶ 37; Grossman Aff. ¶ 33.

¹¹² *State v. Arctic Vill. Council*, 495 P.3d 313, 319–20 (Alaska 2021).

¹¹³ *Id.* at 320 (quoting *State v. Metcalfe*, 110 P.3d 976, 978 (Alaska 2005)).

the case,” meaning that “the issues raised cannot be ‘frivolous or obviously without merit.’”¹¹⁴

Although Planned Parenthood only needs to satisfy one of these two standards to succeed on its motion, here it meets both.¹¹⁵

II. PLANNED PARENTHOOD HAS MADE A CLEAR SHOWING OF PROBABLE SUCCESS ON THE MERITS

Planned Parenthood has made a clear showing of probable success in establishing that the Telehealth Ban violates its patients’ rights to privacy and equal protection under the Alaska Constitution.

A. The Telehealth Ban Violates Planned Parenthood’s Patients’ Right to Privacy

The Telehealth Ban violates Planned Parenthood’s patients’ fundamental right to abortion, as protected by the Privacy Clause of the Alaska Constitution. The Ban burdens Alaskans’ abortion access by needlessly forcing them to travel to a health center in order to access medication abortion, triggering strict scrutiny. It cannot survive strict scrutiny because there is no justification—much less a compelling one—for banning the use of DTP telehealth to provide medication abortions.

¹¹⁴ *Id.* (quoting *Metcalfe*, 110 P.3d at 978).

¹¹⁵ The fact that the Telehealth Ban is currently in effect does not change the analysis. When the superior court granted a preliminary injunction preventing the State from continuing to enforce Alaska law that prohibited advanced practice clinicians from providing medication abortions, it held that “the length of time for which a statute has been in force is irrelevant to the injunctive relief inquiry.” *Planned Parenthood Great Nw. v. State*, No. 3AN-19-11710, 2021 WL 12353119, at *3 n.32 (Alaska Super. Ct. Nov. 2, 2021).

The Alaska Constitution explicitly protects the right to privacy, providing more robust protections than the implicit protections afforded to privacy by the federal Constitution.¹¹⁶ And as the Alaska Supreme Court has repeatedly recognized over the past twenty-nine years, this Privacy Clause protects the fundamental right to abortion.¹¹⁷

Laws and regulations that “place[] a burden on” a fundamental right trigger strict scrutiny.¹¹⁸ Because the right to abortion is a fundamental right protected by the Alaska Constitution’s Privacy Clause, the Alaska Supreme Court has regularly applied strict scrutiny to laws and policies that burden a pregnant person’s ability to have an abortion. For instance, the Court applied strict scrutiny to the restrictive abortion policy of a quasi-public hospital¹¹⁹ and to a law that required minors to involve their parents before having an abortion.¹²⁰ Under strict scrutiny, the State cannot burden the right to abortion unless “the constraints are justified by a compelling state interest, and no less restrictive means could advance that interest.”¹²¹

The Telehealth Ban burdens Alaskans’ right to abortion and thus triggers strict scrutiny. The Ban prohibits providing medication abortions via DTP telehealth, the only

¹¹⁶ Alaska Const. art. I, § 22; *Valley Hosp. Ass’n*, 948 P.2d at 968; *State v. Planned Parenthood of Alaska*, 171 P.3d 577, 581 (Alaska 2007) [hereinafter “*Planned Parenthood III*”].

¹¹⁷ See, e.g., *Valley Hosp. Ass’n*, 948 P.2d at 969; *Planned Parenthood I*, 28 P.3d at 909; *Planned Parenthood III*, 171 P.3d at 581.

¹¹⁸ *Planned Parenthood III*, 171 P.3d at 582.

¹¹⁹ *Valley Hosp. Ass’n*, 948 P.2d at 971–72.

¹²⁰ *Planned Parenthood III*, 171 P.3d at 582.

¹²¹ *Valley Hosp. Ass’n*, 948 P.2d at 969, 971; see also *State v. Planned Parenthood of Alaska*, 35 P.3d 30, 41 (Alaska 2001) [hereinafter “*Planned Parenthood II*”]; *Planned Parenthood III*, 171 P.3d at 582.

form of abortion care that eliminates the need for patients to travel for their care. Rather than allow patients to have a medication abortion from their home or another location of their choosing, the Ban forces every Alaskan seeking a medication abortion to travel to one of the only two health centers that provide abortions in the state—located in Anchorage and Fairbanks—even though such a visit is typically not medically necessary.¹²²

Research shows that increased travel distances, like the ones caused by this Telehealth Ban, delay patients in accessing abortions and prevent some patients from having an abortion altogether.¹²³ The Ban thus often forces those who face barriers to traveling to a health center to continue carrying their pregnancies, with all the risks of complications and mortality that doing so brings.¹²⁴ These burdens are felt disproportionately by Alaska Native and Black women and rural residents, all of whom have higher rates of maternal morbidity and mortality.¹²⁵ In addition, by requiring many patients to arrange for travel, childcare, or time off work to have an abortion, the Ban endangers individuals who have violent partners by making it harder for them to keep their pregnancy and their abortion plans confidential.¹²⁶ By burdening Alaskans' abortion access, the Telehealth Ban triggers strict scrutiny.

¹²² See *supra* Background Sections III, V.

¹²³ See Grossman Aff. ¶¶ 52, 62–64.

¹²⁴ See McNicholas Aff. ¶ 29; Grossman Aff. ¶¶ 33, 52, 66, 69.

¹²⁵ See *supra* notes 40, 111.

¹²⁶ See *Valley Hosp. Ass'n*, 948 P.2d at 968 n.8 (“If a woman is unable to obtain an abortion near her home, there is an increased chance that she will have to reveal her pregnancy to others in order to arrange the necessary travel. The fact that a woman has visited a certain doctor can be intensely private, when the doctor is one who specializes in abortion services.”).

No interest—let alone a compelling one—justifies the Telehealth Ban. In examining whether a compelling interest justifies burdening the right to abortion, the Alaska Supreme Court has asked whether there is a “medical, safety, or other public-welfare interest.”¹²⁷ There is none here. The medical consensus is that providing medication abortions via DTP telehealth is safe and effective, as demonstrated by extensive peer-reviewed medical literature and affirmed by all the major medical organizations that have weighed in on the topic.¹²⁸ Rather than improve Alaskans’ health or serve any other medical, safety, or public welfare interest, the Telehealth Ban *harms* Alaskans. As noted *supra* in Background Section V, the Ban delays and denies Alaskans’ access to essential health care, forcing them to continue carrying their pregnancies and subjecting them to risks of complications and mortality. As the Supreme Court recognized in *Planned Parenthood I*, “some women—particularly those who suffer from pre-existing health problems—face significant risks if they cannot obtain abortions.”¹²⁹ The Telehealth Ban also makes it more likely that patients seeking an abortion will have to do so later in pregnancy, when the risk of abortion-related complications is higher.¹³⁰

¹²⁷ *Valley Hosp. Ass’n*, 948 P.2d at 971.

¹²⁸ See McNicholas Aff. ¶¶ 19–25, 27, 39; Grossman Aff. ¶¶ 41–43, 47–48.

¹²⁹ *Planned Parenthood I*, 28 P.3d at 907.

¹³⁰ See Grossman Aff. ¶ 66. To the extent that the State asserts a compelling interest, Planned Parenthood is prepared to show that the Telehealth Ban is not the least restrictive means of advancing any such purported interest, including because the State has made no effort to tailor the ban and has instead categorically prevented patients from having a medication abortion via DTP telehealth. *Cf. Planned Parenthood III*, 171 P.3d at 583 (holding that a parental consent law was not the least restrictive means of advancing the State’s interests even though it “recognize[d] that the legislature ha[d] made a serious effort to narrowly tailor the scope” of the law).

Other state courts have held that similar bans on providing medication abortions via DTP telehealth violate their state constitutions. Under the Montana Constitution’s right to privacy, the Montana Supreme Court has twice upheld injunctions against laws that banned or effectively prevented patients from using DTP telehealth to have medication abortions.¹³¹ In one of these cases, the Montana Supreme Court held that a ban on providing medication abortions via DTP telehealth violated the right to privacy and that no compelling interest justified doing so, including because the court had been presented with “evidence that telehealth medication abortions are safe, acceptable, effective, and improve access to care.”¹³² The Superior Court of Arizona also recently held that a ban on telehealth abortion care—including the use of DTP telehealth—violated the fundamental right to abortion under the Arizona Constitution, holding that the ban was not justified by a compelling state interest because it did not “‘improve or maintain’ the health of a woman seeking an abortion.”¹³³ The court reached this conclusion based on evidence that “[t]elemedicine abortion is safe and effective, based on accepted clinical standards of practice and evidence-based medicine,” and that, “for many patients, telemedicine makes the difference between accessing timely abortion care or being delayed or prevented in accessing care.”¹³⁴ An Ohio trial court has also preliminarily enjoined a ban on telehealth

¹³¹ See *Planned Parenthood of Mont. v. State*, 570 P.3d 51, 81 (Mont. 2025); *Planned Parenthood of Mont. v. State*, 557 P.3d 471, 482–84 (Mont. 2024).

¹³² *Planned Parenthood of Mont.*, 570 P.3d at 79–81.

¹³³ Minute Entry ¶¶ 94–100, *Isaacson v. State*, No. CV 2025-017995, 2026 WL 1009001 (Ariz. Super. Ct. Feb. 6, 2026) (quoting *Isaacson*, 2026 WL 1009001, ¶ 13).

¹³⁴ *Id.* ¶¶ 50, 84.

medication abortions, holding that the ban did not survive strict scrutiny in part because it burdened “patients seeking medication abortion, such as [by] increasing their travel distance to obtain an abortion and by imposing numerous other attendant harms, which will delay patients in obtaining an abortion and prevent some from obtaining a medication abortion altogether.”¹³⁵

For the foregoing reasons, a preliminary injunction is warranted because Planned Parenthood has made a clear showing of probable success on its privacy claim.

B. The Telehealth Ban Violates Planned Parenthood’s Patients’ Right to Equal Protection

The Telehealth Ban also violates Planned Parenthood’s patients’ right to equal protection. The Ban singles out pregnant patients who seek an abortion for discriminatory treatment with no justification, preventing them from using DTP telehealth to have an abortion, while allowing patients who seek other forms of health care—including other pregnancy-related care—to use DTP telehealth.

The Alaska Constitution provides that “all persons are equal and entitled to equal rights, opportunities, and protection under the law,”¹³⁶ “mandat[ing] ‘equal treatment of those similarly situated.’”¹³⁷ As with the Privacy Clause, the Alaska Supreme Court has

¹³⁵ Entry Granting Pls.’ Mot. for a Prelim. Inj. at 10–11, *Planned Parenthood Sw. Ohio Region v. Ohio Dep’t of Health*, No. A2101148 (Ohio Ct. Common Pleas Apr. 19, 2021).

¹³⁶ Alaska Const. art. I, § 1.

¹³⁷ *Planned Parenthood I*, 28 P.3d at 909 (quoting *Alaska Pac. Assurance Co. v. Brown*, 687 P.2d 264, 271 (Alaska 1984)).

“long recognized” that Alaska’s Equal Protection Clause “affords greater protection to individual rights than the United States Constitution’s Fourteenth Amendment.”¹³⁸

In an equal protection challenge, a court first “determin[es] the appropriate comparison classes” and then determines whether those “classes are treated unequally.”¹³⁹ Next, to determine whether the distinction between the classes is unconstitutional, a court uses a three-step sliding scale framework. Under this framework, the court: (1) determines “what weight should be afforded the constitutional interest impaired by the challenged enactment”; (2) examines “the purposes served by a challenged statute”; and (3) evaluates “the particular means employed to further [the State’s] goals” to determine the degree of fit. In the abortion context, the third step includes asking whether the law is either under-inclusive or over-inclusive because it “treat[s] abortion *differently* from childbirth and other pregnancy care—the statute and regulation should be neither under-inclusive nor over-inclusive.”¹⁴⁰

As a threshold matter, the Telehealth Ban singles out pregnant patients seeking to terminate their pregnancies for unequal treatment, while allowing similarly situated groups to use DTP telehealth to access care, including both (i) Alaskans who seek other pregnancy-related care and (ii) Alaskans who seek all other types of care for which there is similarly no medical need for an in-person visit. Regardless of which comparison class is applied,

¹³⁸ *Alaska C.L. Union v. State*, 122 P.3d 781, 785 n.16, 787–88 (Alaska 2005) (quoting *Malabed v. North Slope Borough*, 70 P.3d 416, 420 (Alaska 2003)).

¹³⁹ *Planned Parenthood V*, 436 P.3d at 1000 (quoting *Planned Parenthood IV*, 375 P.3d at 1135).

¹⁴⁰ *Id.* at 1004.

Planned Parenthood is likely to succeed on this claim. First, as the Alaska Supreme Court explained in *Planned Parenthood I*, “a woman who carries her pregnancy to term and a woman who terminates her pregnancy exercise the same fundamental right to reproductive choice,” and “Alaska’s equal protection clause does not permit governmental discrimination against either woman.”¹⁴¹ The Telehealth Ban requires patients seeking an abortion to travel to a health center to obtain this care while allowing pregnant patients who seek to carry their pregnancies to term to obtain pregnancy-related care from their home or any other location they choose. Second, Alaskans who seek to end a pregnancy via DTP telehealth are also similarly situated to the broader group of Alaskans who seek any other type of health care for which there is no medical need for an in-person visit. Although Alaska law authorizes the latter of these classes to seek care via DTP telehealth, it prohibits the former from doing so, singling out abortion for differential treatment from other forms of health care.¹⁴²

Applying the three-step framework demonstrates that the Telehealth Ban violates Planned Parenthood’s patients’ right to equal protection. First, the Court determines what interest is impaired; the importance of that interest determines the scrutiny that the court must apply.¹⁴³ Here, the right impaired is the right to access an abortion, which is a

¹⁴¹ *Planned Parenthood I*, 28 P.3d at 913.

¹⁴² *Planned Parenthood II*, 35 P.3d at 43 (recognizing that Alaska law “generally authoriz[ed] all minors who live on their own—regardless of whether they are formally emancipated—to consent to any form of medical or dental treatment except abortion,” and holding that this distinction “fall[s] within the ambit of the equal protection question raised in this case and deserve[s] careful scrutiny”).

¹⁴³ *Id.*

fundamental right protected by the Alaska Constitution.¹⁴⁴ As the Supreme Court has stated, “it has long been established that a law burdening the fundamental right of reproductive choice demands strict scrutiny.”¹⁴⁵ A law “need not expressly forbid the exercise of the right” to trigger strict scrutiny; strict scrutiny is also applied “where the government, by selectively denying a benefit to those who exercise a constitutional right, effectively deters the exercise of that right.”¹⁴⁶ The Telehealth Ban here effectively deters the exercise of the fundamental right to abortion. By broadly authorizing Alaskans to access health care—including other pregnancy-related care—via DTP telehealth but prohibiting them from using that same telehealth model to have an abortion, the Ban makes it more difficult for Alaskans who face travel obstacles to have an abortion. The Ban thus triggers strict scrutiny.

Second, the Court examines the purposes served by the challenged statute. Because the Telehealth Ban burdens a fundamental right, the State must establish that the purpose served by the Ban is compelling.¹⁴⁷ There is no reason—let alone a compelling one—that justifies the Telehealth Ban’s discriminatory treatment of Alaskans who seek a medication abortion. As shown above, medication abortions can be safely and effectively provided via DTP telehealth. No medical, safety, or other public welfare reason justifies preventing

¹⁴⁴ See, e.g., *Valley Hosp. Ass’n*, 948 P.2d at 969; *Planned Parenthood I*, 28 P.3d at 909; *Planned Parenthood III*, 171 P.3d at 581.

¹⁴⁵ *Planned Parenthood V*, 436 P.3d at 1001 (quoting *Planned Parenthood IV*, 375 P.3d at 1137–38).

¹⁴⁶ *Id.* (quoting *Planned Parenthood I*, 28 P.3d at 909).

¹⁴⁷ *Id.*

pregnant patients from using DTP telehealth to have a medication abortion while simultaneously allowing other pregnant patients to use the same telehealth model to seek other pregnancy-related care, including obtaining the exact same medications used for medication abortions to manage a miscarriage.¹⁴⁸ Nor does any medical, safety, or other public welfare reason justify preventing Alaskans from using DTP telehealth to have an abortion when the law broadly authorizes the use of DTP telehealth for other forms of health care.

Third, the Court examines the fit between the State’s purported goals and the means chosen to achieve those goals. Because the Telehealth Ban burdens Alaskans’ fundamental right to abortion, “the fit between means and ends must be much closer” than when a fundamental right is not involved.¹⁴⁹ The State “bears the burden of proving ‘that the means it has chosen to advance [its] goals are well-fitted to the ends.’”¹⁵⁰ Even if the State could articulate a compelling interest here—which it cannot—the Telehealth Ban could not plausibly be appropriately fitted to any purported interest. The Ban is under-inclusive because it “treat[s] abortion *differently* from childbirth and other pregnancy care.”¹⁵¹ It only prohibits pregnant patients who want an abortion from accessing care via DTP telehealth, not also pregnant patients who want other pregnancy-related care. The Ban is also under-

¹⁴⁸ See *Planned Parenthood Great Nw. v. State*, No. 3AN-19-11710CI, 2024 WL 5411729, at *5 (Alaska Super. Ct. Sept. 4, 2024) (“Medication management of miscarriage involves the use of mifepristone and misoprostol in the same dosages as for medication abortion and requires the same provider skills.”).

¹⁴⁹ *Planned Parenthood V*, 436 P.3d at 1001.

¹⁵⁰ *Id.* at 1004 (quoting *Planned Parenthood I*, 28 P.3d at 909).

¹⁵¹ *Id.* at 1000, 1004.

inclusive because, of all the types of health care that can be provided without an in-person visit, the Telehealth Ban singles out only one—abortion—for unequal treatment.¹⁵²

For these reasons, a preliminary injunction is warranted because Planned Parenthood has made a clear showing of probable success on the merits of its equal protection claim.

III. THE BALANCE OF HARDSHIPS FAVORS PLANNED PARENTHOOD’S PATIENTS

A preliminary injunction is also warranted under the balance-of-hardships standard. A preliminary injunction is warranted under this standard where: (1) the plaintiff faces irreparable harm if the challenged law is not enjoined; (2) the opposing party would be “adequately protected” from harm if the injunction were granted; and (3) the plaintiff has “raise[d] ‘serious’ and substantial questions going to the merits of the case,” meaning that “the issues raised cannot be ‘frivolous or obviously without merit.’”¹⁵³ Planned Parenthood has more than met this test.

¹⁵² The Telehealth Ban is also over-inclusive because it requires every patient seeking a medication abortion to travel to a health center regardless of their circumstances. As discussed above, while it is not typically medically necessary for a patient to have an ultrasound or other physical testing before a medication abortion, abortion providers’ screening protocols identify some patients who need such testing. *See* McNicholas Aff. ¶¶ 21–22; Grossman Aff. ¶ 42. But the Telehealth Ban reaches far beyond those limited circumstances, requiring all patients to travel to a health center in Anchorage or Fairbanks and applying to each and every patient regardless of their circumstances. *See Planned Parenthood V*, 436 P.3d at 1001 (“[I]f the purpose can be accomplished by a less restrictive alternative, the classification will be invalidated.”). And in any event, the evidence demonstrates that patients whose circumstances warrant an in-person visit can be identified effectively via the DTP telehealth screening process. *See* McNicholas Aff. ¶¶ 21–22.

¹⁵³ *Arctic Vill. Council*, 495 P.3d at 320 (quoting *Metcalfe*, 110 P.3d at 978).

Planned Parenthood’s patients will continue to face irreparable harm if the Telehealth Ban is not preliminarily enjoined. The Alaska Supreme Court has explained that “[i]rreparable harm is an injury which should not be inflicted and which, ‘because it is so large or so small, or is of such constant and frequent occurrence, or because no certain pecuniary standard exists for the measurement of damages, cannot receive reasonable redress in a court of law.’”¹⁵⁴ The Telehealth Ban inflicts irreparable harm on Alaskans that cannot be redressed in a court of law. The Ban deprives Alaskans of the option of accessing abortion care through DTP telehealth, forcing them to travel up to hundreds of miles to a health center in Anchorage or Fairbanks, including at great difficulty and expense.¹⁵⁵ Research shows that increased travel distance is associated with delays in abortion access and can prevent patients from accessing abortion altogether.¹⁵⁶ Studies consistently show a significant association between increasing distance to the nearest health center that provides abortions and a decline in the number of abortions.¹⁵⁷ These challenges are heightened in Alaska due to the state’s size, geography, and the significant distances that patients must often travel to reach a health center.¹⁵⁸

Even those who are ultimately able to have an abortion after overcoming barriers imposed by travel face delays in doing so, which subjects them to increased risks of

¹⁵⁴ *State v. Galvin*, 491 P.3d 325, 333 (Alaska 2021) (quoting *State v. Kluti Kaah Native Vill. of Copper Ctr.*, 831 P.2d 1270, 1273 n.5 (Alaska 1992)).

¹⁵⁵ See McNicholas Aff. ¶¶ 29, 35; Grossman Aff. ¶¶ 52, 59–65.

¹⁵⁶ See Grossman Aff. ¶¶ 52, 62–64.

¹⁵⁷ See *id.* ¶¶ 62–64.

¹⁵⁸ See *supra* Background Section V.

abortion complications later in pregnancy and the health risks of remaining pregnant for longer.¹⁵⁹ For instance, a study found that rural women in Washington State who had to travel more than seventy-five miles to have an abortion were two to three times more likely than women traveling less than seventy-five miles to terminate their pregnancy after 12 weeks LMP—the point of pregnancy up to which Planned Parenthood provides medication abortions in Alaska.¹⁶⁰ The Ban also forces abortion patients to risk the confidentiality of their decision, which particularly endangers patients at risk of or experiencing intimate partner violence.¹⁶¹ These harms cannot be redressed in a court of law and are thus irreparable.

In contrast, the State will be adequately protected from harm if a preliminary injunction is issued; in fact, it will face no harm at all. The Alaska Supreme Court has explained that “[a]dequate protection’ generally means that the party opposing the injunction can be indemnified by a bond when financial harm is at stake; can be otherwise protected by some action; or, at a minimum, is facing only ‘relatively slight’ harm compared to the potential harm facing the party seeking relief.”¹⁶² As set forth more fully in Background Section V, the Ban not only fails to further the health of Alaskans but instead harms their health. The State accrues no benefit from enforcing a law that harms

¹⁵⁹ See McNicholas Aff. ¶ 29; Grossman Aff. ¶¶ 33, 52, 66, 69.

¹⁶⁰ See Grossman Aff. ¶ 62.

¹⁶¹ See McNicholas Aff. ¶ 33; Grossman Aff. ¶ 71.

¹⁶² *Galvin*, 491 P.3d at 333 (quoting *Kluti Kaah Native Vill. of Copper Ctr.*, 831 P.2d at 1273).

Alaskans’ health, and would face no harm from being denied the ability to enforce this unconstitutional abortion restriction while the lawsuit proceeds.¹⁶³

Finally, for the reasons articulated in Argument Section II, Planned Parenthood has raised serious and substantial questions going to the merits of its privacy and equal protection claims. Although Planned Parenthood maintains that it has met the higher burden of a clear showing of probable success on the merits of these claims, it has also—at minimum—met the lesser burden of showing that its claims are not frivolous or obviously without merit.

CONCLUSION

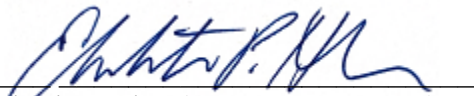
Under both the probable-success-on-the-merits and the balance-of-hardships standards, Planned Parenthood has made the required showings warranting a preliminary injunction against the Telehealth Ban. Planned Parenthood respectfully requests that this Court enter the attached proposed order.¹⁶⁴

¹⁶³ See *Duncan v. Bonta*, 83 F.4th 803, 822 (9th Cir. 2023) (noting that a state “can have ‘no legitimate interest in enforcing an unconstitutional ordinance’” (quoting *KH Outdoor, LLC v. City of Trussville*, 458 F.3d 1261, 1272 (11th Cir. 2006))).

¹⁶⁴ No bond should be required under Alaska Rule of Civil Procedure 65(c). This Court has discretion to “dispense with the filing of a bond when it concludes there is no realistic likelihood of harm to the defendant from enjoining [its] conduct,” and may do so when the defendant “is not likely to suffer monetary damages as a result of [the] injunction.” *Bitler v. Lindquist*, No. 3PA-16-2058, 2016 WL 11984026, at *3 (Alaska Super. Ct. Nov. 15, 2016); cf. *Galvin*, 491 P.3d at 333 (in the context of describing “adequate protection” for the balance-of-hardships standard, suggesting that a party being “indemnified by a bond” would occur “*when financial harm is at stake*” (emphasis added)). When the superior court granted a preliminary injunction preventing the State from enforcing Alaska law that prohibited advanced practice clinicians from providing medication abortions, it also did so without requiring a bond. See *Planned Parenthood Great Nw.*, 2021 WL 12353119. Here, as in that case, no financial harm to the State is at stake. The State will not incur “costs and

Dated this 11th day of June, 2026.

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damages” from being unable to enforce the Telehealth Ban, and no bond should be
required. Alaska R. Civ. P. 65(c).

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Certificate of Service

I certify that on the 11th day of June 2026, a true and correct copy of the foregoing document was served on the following with summons:

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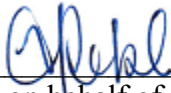
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