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*

Mary Brault - Judicial Assistant

Alaska Statute 47.07.068. Payment for abortions.

(a) The department may not pay for abortion services under this chapter unless the abortion services are for a medically necessary abortion or the pregnancy was the result of rape or incest. Payment may not be made for an elective abortion.

(b) In this section,

(1) "abortion" has the meaning given in AS 18.16.090;

(2) "elective abortion" means an abortion that is not a medically necessary abortion;

(3) "medically necessary abortion" means that, in a physician's objective and reasonable professional judgment after considering medically relevant factors, an abortion must be performed to avoid a threat of serious risk to the life or physical health of a woman from continuation of the woman's pregnancy;

(4) "serious risk to the life or physical health" includes, but is not limited to, a serious risk to the pregnant woman of

(A) death; or

(B) impairment of a major bodily function because of

(i) diabetes with acute metabolic derangement or severe end organ damage;

(ii) renal disease that requires dialysis treatment;

(iii) severe pre-eclampsia;

(iv) eclampsia;

(v) convulsions;

(vi) status epilepticus;

(vii) sickle cell anemia;

(viii) severe congenital or acquired heart disease, class IV;

(ix) pulmonary hypertension;

(x) malignancy if pregnancy would prevent or limit treatment;

(xi) kidney infection;

(xii) congestive heart failure;

(xiii) epilepsy;

(xiv) seizures;

(xv) coma;

(xvi) severe infection exacerbated by pregnancy;

(xvii) rupture of amniotic membranes;

(xviii) advanced cervical dilation of more than six centimeters at less than 22 weeks gestation;

(xix) cervical or cesarean section scar ectopic implantation;

(xx) any pregnancy not implanted in the uterine cavity;

(xxi) amniotic fluid embolus; or

(xxii) another physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy that places the woman in danger of death or major bodily impairment if an abortion is not performed.

ALASKA STATE SENATE

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SENATOR JOHN COGHILL

Date: April 1, 2013

To: Finance Committee Members

From: Sen. John Coghill's Office

Re: SB 49

Rebuttal to Planned Parenthood and Testimony from Saturday, March 30, 2013

1. The testimony was broad and, at times, emotional. That is generally a common trait when debating issues involving abortion.
2. Sen. Coghill wants to correct some misunderstandings about the bill including some misunderstandings that come from its opponents.

POINT 1 - PLANNED PARENTHOOD STILL COULD NOT CEARLY DEFINE WHAT AN ELECTIVE ABORTION WAS OR THAT ELECTIVE ABORTIONS EVEN EXIST.

a. Of course, a reasonable person could argue that Planned Parenthood cannot openly clearly admit that elective abortions exist because that would make them elective procedures.
    i. As we are all aware elective procedures are not covered under Medicaid.
    ii. Paying for elective procedures would therefore be an open abuse of Medicaid.

POINT 2 - SB 49 DOES SATISFY EQUAL PROTECTION.

1. The 2001 Supreme Court Opinion stated that the State has to provide medically necessary care for women seeking to give birth to a child.
2. The court also stated that the State has to provide medically necessary care for women seeking an abortion.
    a. What some opponents, even to this day, fail to recognize is the Supreme Court directed that a definition for a medically necessary abortion can be crafted as long as we base it on neutral criteria directly related to the health care program. See tab 4c, Page 16

highlighted portion. That is what SB 49 does. It was based on the very language of the 2001 Planned Parenthood decision and includes direct language found in the federal Hyde Amendment. The conditions are neutral and taken specifically from doctors in the field.

i. One doctor disagreed with the conditions on Saturday. What she may or may not know is that the conditions were overwhelmingly directly taken from the 2001 *Planned Parenthood* decision.

POINT 3 – SB 49 UNFAIRLY TARGETS POOR WOMEN?

1. The US Supreme Court, long ago ruled that the Federal Constitution **does not** require a State to pay for the costs of elective abortions just because it pays for the costs of childbirth related medical care. See *Maher v. Roe*, 432 US 464, 474 (1977)
2. 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).

POINT 4 – OTHER ATTEMPTS TO LIMIT ABORTIONS SINCE 2001 MAY OR MAY NOT HAVE BEEN SUCCESSFUL.

1. SB-49 has nothing to do with those attempts. We cannot comment on the reasons they may or may not have been successful. This is a total different focus. SB-49 is a "lean muscle" bill. We have high confidence in how thorough and specific the bill is drafted.

POINT 5 – SURVIVAL OF FETUS IS NOT CONSIDERED?

1. That is simply incorrect. We've heard testimony as to the "floating tomb" and the child being "brainless." We considered that option and incorporated Paragraph 4, B, 22 (See Tab 1). "Another physical disorder...arising from the pregnancy....that would be a major bodily impairment."

POINT 6 – AN OPPONENT OF THE BILL STATED THAT YOU CANNOT SEPARATE "PHYSICAL HEALTH" AND "MENTAL HEALTH."

1. With all due respect, President Obama via Executive Order 13535, case law, and the very existence of the Hyde Amendment prove otherwise. Sen. Coghill invites you to look at tab 7 in your binders. The language is clear to emphasize "physical disorder", "physical injury", or "physical illness." It specifically does not include mental or psychological disorders.
2. In addition, SB 49 supporters, including 3 national doctors and 7 Alaskan doctors fundamentally disagree with that presumption. There is a genuine disagreement in the medical community

that mental and psychological conditions should be included under the definition of "medically necessary abortion."

APPENDIX B – *Planned Parenthood v. Streur* (3AN-14-04711CI)

28th Legislature (2013-2014)
Committee Minutes
SENATE JUDICIARY
Feb 27, 2013

SB 49-MEDICAID PAYMENT FOR ABORTIONS; TERMS

1:34:43 PM
CHAIR COGHILL announced the consideration of SSSB 49. Speaking as the prime sponsor, he stated that the bill intends to add clarification.

1:35:54 PM
CHAD HUTCHINSON, staff to Senator John Coghill, sponsor of SB 49, stated that this legislation has been years in the making and has gone through a thorough, clinical analysis by both legal and medical experts. It is about defining what a medically necessary abortion is for the purposes of making payments under Medicaid.

He clarified that there is no intent to reargue the 2001 Planned Parenthood case. The sponsor recognizes that Alaska has the constitutional guarantee to provide medically necessary care for qualified people of limited resources, including women requesting medically necessary abortions. The difficulty is that no one has defined what that is, so SB 49 seeks to provide that definition.

MR. HUTCHINSON stated that the definition provided in the bill incorporates the statutory foundation required by the federal Hyde Amendment. That amendment is an important component in a lot of abortion legislation and was included in an executive order by President Barak Obama in 2010.

1:38:27 PM
SENATOR OLSON joined the committee.

MR. HUTCHINSON read a portion of the policy stated in Section 1 of Executive Order 13535 of March 24, 2010 as follows:

> Following the recent enactment of the Patient Protection and Affordable Care Act, it is necessary to establish an adequate enforcement mechanism to ensure that Federal funds are not used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), consistent with a longstanding Federal statutory restriction that is

commonly known as the Hyde Amendment.

MR. HUTCHINSON relayed that those provisions are included in the definitional language of SB 49. He directed attention to tab 7, which has up to date language with regard to what the Hyde Amendment says, and suggested members compare that language with what is included in the bill.

He pointed out that the Alaska Constitution requires protection that is higher than the federal standard, and the bill reflects that added protection in subsection (b)(4) on page 2. He noted that the provisions in this section were taken directly from the 2001 Planned Parenthood case or provided by the sponsor's medical experts.

1:41:55 PM

MR. HUTCHINSON directed attention to the sectional under tab 3 and explained that it contains the foundational elements for putting the bill in context. He reiterated that the bill only defines medically necessary abortions for the purposes of making payments under Medicaid. The intent is to distinguish between what constitutes a medically necessary abortion and an elective abortion.

He clarified that Medicaid does not fund elective procedures and, therefore, should not fund elective abortions. Medicaid is required to fund medically necessary procedures and, therefore, is required to fund medically necessary abortions.

MR. HUTCHINSON directed attention to tab 4a and the Guttmacher Institute document titled "State Policies in Brief as of February 1, 2013 - State Funding of Abortion Under Medicaid." He pointed out that the background statement, in part, says, "At a minimum, states must cover those abortions that meet the federal exceptions." The document highlights that 32 states and the District of Columbia meet the minimum federal standard and allow state funding of abortion under Medicaid in the circumstance of life endangerment, rape, or incest. It further highlights that 17 other states, including Alaska, fund all or most medically necessary abortions either voluntarily or by court order. Mr. Hutchinson noted that the court order refers to the 2001 Planned Parenthood case.

He directed attention to tab 4c, which contains the Supreme Court of Alaska case State of Alaska, Department of Health & Social Services v. Planned Parenthood of Alaska, Inc. The conclusion, found on page 16, includes the following statement:

> The State, having undertaken to provide health care for poor Alaskans, must adhere to neutral criteria in distributing that care. It may not deny medically necessary services to eligible individuals based on criteria unrelated to the purposes of the public health care program.

MR. HUTCHINSON stated that SB 49 seeks to define medically necessary services based on mutual criteria, directly related to a health care program. He said the committee would hear testimony from experts who would clarify specifically what they believe to be a medically necessary condition in order to qualify for Medicaid funding for an abortion. He highlighted that the sponsor reasonably believes that Medicaid is currently paying for both elective abortions and medically necessary abortions.

1:46:03 PM

MR. HUTCHINSON directed attention to tab 8 and the document from the Alaska Bureau of Vital Statistics showing induced termination of pregnancy statistics for 2011. He reported that Table 18 shows that the total number of induced terminations was 1,627. The total paid for by Medicaid was 623, or approximately 38.3 percent. He said the general presumption is that those women who qualified stated that there was a rape, incest, it was medically necessary, or the life of the mother was at stake.

MR. HUTCHINSON directed attention to tab 9 and the article from the Guttmacher Institute titled "Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives." On page 114, Table 3 indicates that in 2004, only 4 percent of women having an abortion listed a physical problem with their health as their most important reason for having the abortion, and less than 0.5 percent listed being a victim of rape as their most important reason for having the abortion. Mr. Hutchinson said that these statistics demonstrate that only a small portion of abortions are medically necessary.

He emphasized that the foregoing statistics show that the definition is unclear and that there are no clear guidelines to differentiate between elective and medically necessary. He again stated that SB 49 corrects that by bringing clarity to the definition.

MR. HUTCHINSON noted that tabs 11, 12, and 13 have the curricula vitae (CV) of the experts providing testimony today.

1:48:56 PM

SENATOR WIELECHOWSKI asked if under the Medicaid provisions, Alaska is required to pay for abortions when a doctor certifies that it is medically necessary.

MR. HUTCHINSON deferred the question to someone from the Department of Health and Social Services (DHSS).

SENATOR WIELECHOWSKI asked if he was saying that Medicaid was paying for elective abortions in Alaska.

MR. HUTCHINSON responded that elective procedures are not supposed to be covered under Medicaid. Only medically necessary procedures qualify for Medicaid funding.

SENATOR WIELECHOWSKI asked if he had any evidence of any abortions in the state of Alaska that have been paid for by Medicaid and were elective as opposed to medically necessary.

MR. HUTCHINSON replied that the statistics he cited show that is occurring.

1:51:01 PM
SENATOR WIELECHOWSKI asked if the law in Alaska is that Medicaid funds medically necessary abortions.

MR. HUTCHINSON agreed that is correct.

SENATOR WIELECHOWSKI asked if he had any specific case evidence of any abortions that Medicaid paid for that were not deemed medically necessary by a doctor.

MR. HUTCHINSON responded that in coordination with the Department of Health and Social Services (DHSS) he would follow up with additional information.

SENATOR WIELECHOWSKI asked if he agreed that under current law it would be illegal to fund an abortion that is not medically necessary.

MR. HUTCHINSON agreed that the Alaska Supreme Court said the state has to fund medically necessary abortions under Medicaid.

CHAIR COGHILL, speaking as the prime sponsor, said he believes the state has been funding elective abortions, and the bill seeks to answer the question definitively.

SENATOR WIELECHOWSKI asked if he was aware of a single case in Alaska where a doctor certified that an abortion performed under

Medicaid was elective.

MR. HUTCHINSON responded that the sponsor is aware in the sense that the statistics support the fact that medically necessary has included both elective abortions and medically necessary abortions under the definitions provided in tabs 8 and 9. He offered to follow up and provide additional information.

1:53:05 PM
CHAIR COGHILL added that to his knowledge there has been no prosecution of an elective abortion funded under Medicaid. He offered his belief that the Supreme Court case caused doctors to question when it is medically necessary, and the proposed definition goes to that question.

SENATOR WIELECHOWSKI asked if a woman's physician or a bunch of politicians is in a better position to decide whether a medical procedure is medically necessary.

MR. HUTCHINSON offered his belief that clarification is necessary so that doctors have a clear understanding of the definition for purposes of payment under [Medicaid]. He added that women can still get an abortion; the issue is whether it is paid for by Medicaid.

SENATOR WIELECHOWSKI offered his belief that the issue actually is constitutional rights according to the Alaska Supreme Court.

MR. HUTCHINSON responded that the purpose of the bill is to clarify the overly broad definition so everyone understands the difference between an elective procedure and a medically necessary procedure.

SENATOR COGHILL, speaking as the prime sponsor, stated that the bill does not address the constitutional issue. The issue is one of payment. At this point, it is not to restrict abortion. He said the question is when is an abortion elective and therefore paid by for by the woman, and when is it medically necessary and therefore paid for by Medicaid.

1:55:40 PM
CHAIR COGHILL noted that he called on three professionals to help make the medical case today, but that there would be opportunities for other professionals to provide testimony.

1:56:11 PM
PRICILLA K. COLEMAN, PhD., Professor, Bowling Green State University, said she is a developmental psychologist and

professor of human development and family studies. She has published over 50 peer-reviewed scientific articles, 37 of which are on the psychology of abortion. She relayed that based on her expertise she is often called upon to serve as a content expert in state civil cases involving abortion. She said that the opinions expressed in her testimony are based on her education, professional experience, her personal psychological research, and her ongoing review of the abortion and mental health literature.

She stated that, with a reasonable degree of scientific and medical certainty, she can say that abortion is a substantial contributing factor in women's mental health problems. She continued to offer her opinion that abortion is a particularly risky choice for women with preexisting mental illness. She said there is no empirical evidence that documents mental health benefits to women with or without preexisting mental illness, but there is abundant literature that documents the association between abortion and declining mental health. Dr. Coleman said it is therefore her opinion that abortion is never justified based on mental health and the State of Alaska should not pay for an abortion when a woman has any form of mental illness.

DR. COLEMAN reported that the formal study of the psychology of induced abortion has gathered considerable momentum in the past several decades and the scientific rigor of published studies has likewise increased. She said the literature has focused on the potential negative psychological consequences of induced abortion and the risk factors for such consequences. At the same time, there has been a growing awareness in the medical community of the need for evidence-based practice.

DR. COLEMAN said that most of the scientific evidence indicates that abortion is a substantial contributing factor in women's mental health problems, including depression and death from suicide. Anxiety, substance abuse, and relationship problems are also associated with abortion. She said that this scientific evidence is published in leading peer-reviewed journals and fortified by many prospective studies, so there is confidence in the results. She noted that the testimony she submitted includes: Exhibit A - "Bibliography of Peer-Reviewed Studies on Abortion and Mental Health;" Exhibit B - "Evidence for a Causal Association between Abortion and Mental Health Problems;" and Exhibit C - a report of a meta-analysis she conducted that was published September 1, 2011 in the "British Journal of Psychiatry" titled Abortion and Mental Health: A Quantitative Synthesis and Analysis of Research Published from 1995-2009.

DR. COLEMAN explained that a meta-analysis is a quantitative statistical review of literature wherein the data is converted to a common metric to derive the overall measure of effect. This methodology gives the results more credibility than the results from any individual empirical study or narrative review. She explained that in a meta-analysis, the weighting of any particular study to the final result is based on scientific criteria, not an individual opinion.

She reported that the sample in this meta-analysis consisted of 22 studies, 36 measures of effect, and 877,297 participants, 163,880 of which experienced an abortion. The results indicate that women who aborted experienced an 81 percent increased risk for mental health issues. She said that when compared specifically to unintended pregnancy delivered, the women had a 55 percent increased risk of experiencing mental health problems.

DR. COLEMAN said that separate effects were calculated based on the type of mental health outcome and the results showed the following increased risks: anxiety disorders 34 percent, depression 37 percent, alcohol use/abuse 110 percent, marijuana use/abuse 220 percent, and suicide behaviors 155 percent. The composite population attributable risk (PAR) statistic indicated that 10 percent of the mental health problems were directly attributable to abortion. She emphasized that stringent inclusion criteria were used to avoid bias.

She said that the literature on risk factors for adverse post-abortion psychological consequences is well developed. These include: prior mental health problems, difficulty with the decision, emotional investment in the pregnancy, timing during adolescence or being unmarried, involvement in unstable or violent relationships, conservative views of abortion and/or religious affiliation, second trimester abortions, and feelings of being forced into abortion. She said that internalized beliefs about the humanity of the fetus, moral, religious, and ethical objections to abortion, and feelings of bereavement or loss also distinguish those who suffer.

DR. COLEMAN reported that a well-known abortion provider in 1990 emphasized the role of pre-abortion counseling to evaluate mental status and abortion readiness while stressing the importance of a supportive relationship between the counselor and patient to prevent complications.

She related that for the purpose of litigation in South Dakota she searched professional literature for studies published

between 1970 and 2011, documenting personal, demographic, situational, and relational factors that increase the likelihood of post-abortion psychological problems. She identified 12 risk factors that were documented in at least 10 peer-reviewed journal articles. The risk factors include: 1) Character traits indicative of emotional immaturity, emotional instability, or difficulties coping - 42 studies. 2) Pre-abortion mental health or psychiatric problems - 35 studies. 3) Decision ambivalence, decision doubt, or decisional distress - 29 studies. 4) Conflicted, unsupportive relationships with others - 28 studies. 5) Conflicted, unsupportive relationship with father of child - 24 studies. 6) Desire for the pregnancy, psychological investment in the pregnancy, belief in the humanity of the fetus and/or attachment to the fetus - 21 studies. 7) Repeat or second trimester abortion - 19 studies. 8) Timing during adolescence or younger age - 18 studies. 9) Religious, frequent church attendance, personal values conflict with abortion - 18 studies. 10) Negative feelings and attitudes related to the abortion - 16 studies. 11) Pressure or coercion to get the abortion - 10 studies. 12) Indicators of poor quality abortion care - 10 studies.

2:07:46 PM

DR. COLEMAN concluded that her opinion is that there is never justification for abortion on mental health grounds, because the evidence suggests that an abortion will exacerbate pre-existing mental illness and has significant potential to initiate mental illness in women without a prior history. She continued that there is no scientific evidence that women with mental illness are best served by the provision of abortion services when facing an unplanned pregnancy, and she does not believe that public funds should be used for this purpose.

2:08:51 PM

SENATOR WIELECHOWSKI asked if she prepared and delivered a PowerPoint presentation on abortion where she said:

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

DR. COLEMAN said yes; it was in the context of a presentation to the American Association of Prolife OBGYNs.

SENATOR WIELECHOWSKI asked if she issued a report in 2009 for

the Journal of Psychiatric Research linking abortion and mental health, much like the testimony today.

DR. COLEMAN said yes; an abundance of research documents that increased risk.

SENATOR WIELECHOWSKI asked if the Guttmacher Institute wrote an article about her report in the Journal of Psychiatric Research titled, "Study Purporting to Show Link between Abortion and Mental Health Outcomes Decisively Debunked."

DR. COLEMAN said that article was not related to the meta-analysis. It refers to one paper that had an error that was corrected. The article is still a publication in the journal and the findings are considered credible. She acknowledged that the meta-analysis was challenged many times, and opined that it was because she was providing information that was not politically correct and contrary to some agendas. She said she was able to address the criticisms, but she believes that the problem is that people aren't familiar with a quantitative review. They're more accustomed to the biased, politically driven summaries offered by professional organizations. For example, the American Psychological Association over three decades ago declared a prochoice position without data to support that position.

CHAIR COGHILL asked if it was true that the Guttmacher Institute has a particular point of view.

DR. COLEMAN said that is her belief.

2:12:17 PM
SENATOR DYSON asked Dr. Coleman her perspective, because he always thought the Guttmacher Institute reporting was credible with regard to numbers of abortions.

DR. COLEMAN said it is the largest body providing data on abortions, and it also has a history of being connected with prochoice groups.

SENATOR DYSON recalled seeing statistics from the Guttmacher Institute that show that a small percentage of abortions are done for medical reasons. He said he assumes that the statistics are reasonable accurate.

DR. COLEMAN said she was not prepared to critique their methods, but the basic information is likely accurate.

2:14:30 PM

SENATOR WIELECHOWSKI asked if she agreed with the statement Julia Steinberg made after the Journal of Psychiatric Research reviewed her article in 2009. Dr. Steinberg said:

> This is not a scholarly difference of opinion; their facts were flatly wrong. This was an abuse of the scientific process to reach conclusions that are not supported by the data. The shifting explanations and misleading statements that they offered over the past two years served to mask their serious methodological errors.

DR. COLEMAN refuted Dr. Steinberg's statement.

CHAIR COGHILL asked if her perspective is that mental conditions like bipolar should not be included in the definition of medical necessity.

DR. COLEMAN agreed saying that it's likely that providing abortions for women who have serious mental health problems will result in more claims related to mental health problems following the abortion. She continued that it is her opinion that nothing in the literature justifies providing abortion services for mental health reasons, so an abortion is never medically necessary.

2:16:16 PM
SENATOR WIELECHOWSKI asked if she believes that she is in a better position to evaluate a woman's need for medical care than the woman's personal physician.

DR. COLEMAN said that doctors ought to be informed by the literature, and their advice should be based on what multiple professions know. She said she would ask the doctor the basis of his/her opinion.

SENATOR WIELECHOWSKI asked if it was correct that she couldn't have that conversation if this bill were to pass.

DR. COLEMAN said the point is that anyone dealing with a woman who is trying to decide whether to have an abortion or not should be informed by the literature. She said it is her opinion that it would be unethical for a doctor to tell a woman with a medical health problem that she would be better served if she aborted.

SENATOR WIELECHOWSKI pointed out that she is saying that she is in a better position to make that determination than the woman's

doctor.

CHAIR COGHILL summarized his understanding of the testimony, which is that there is no psychological reason to abort a child.

DR. COLEMAN said that is correct.

2:18:54 PM
JOHN THORP, MD., University of North Carolina, said he is an obstetrician who has practiced maternal fetal medicine, high-risk obstetrics, since 1983. He provided his credentials as a professor in the schools of medicine and public health. He noted he has had over 300 peer-reviewed publications.

DR. THORP related that he worked with the sponsor's staff to develop a list of conditions that unequivocally threaten the life of a mother and would constitute a solid medical indication for a termination of pregnancy. These are conditions that would be recommended as options to protect a woman's health, even for women who wanted to continue their pregnancy or who would not consider abortion.

He noted that he has had experience in suburban/rural areas with a large Native American population and many military personnel, where the issue of the use of federal or state funds for pregnancy termination is a frequent topic.

He opined that the comprehensive list in the bill of conditions has enough specificity about the degree of severity that would be helpful to the state of Alaska as it tries to work on the legislation.

2:22:55 PM
CHAIR COGHILL mentioned the previous testimony talking about psychological issues, and noted Dr. Thorp's testimony is about the physical risk to the life and physical health of the mother. He inquired if most of the situations listed in the bill are in the category of life endangering.

DR. THORP said yes.

CHAIR COGHILL noted that, for the most part, the list came from the Supreme Court.

2:24:27 PM
SENATOR DYSON suspected that after a pregnant woman has been subject to an accident, there may be circumstances to consider that would lead to the termination of the pregnancy.

DR. THORP replied that, short of massive bleeding, termination of pregnancy is always an elective procedure. He said that the physician would treat the trauma and a pregnancy makes little difference in these traumas. He couldn't recall a time when a termination would have saved a mother's life.

SENATOR WIELECHOWSKI asked if he would agree that an ultrasound scan for a pregnant woman is a medically necessary procedure.

DR. THORP said not necessarily.

SENATOR WIELECHOWSKI asked if he testifies in other states about abortion issues.

DR. THORP said yes, and recalled that he was in Anchorage at this time last year.

SENATOR WIELECHOWSKI asked if he testified in North Carolina about a requirement for trans-vaginal ultrasounds for most abortions.

DR. THORP said he didn't recall ever having testified in North Carolina.

SENATOR WIELECHOWSKI asked if he attempted to intervene in a lawsuit in North Carolina requiring ultrasounds for abortions.

DR. THORP said not that he recalled.

SENATOR WIELECHOWSKI asked if he made a statement saying, "In my medical opinion, receiving an ultrasound scan and accompanying descriptive information, as mandated by the Act, is essential for a women's consent to be fully formed and voluntary."

DR. THORP said he didn't recall making that statement.

SENATOR WIELECHOWSKI asked if he agrees with that statement.

DR. THORP said he would need the context in order to agree or disagree.

SENATOR WIELECHOWSKI asked if he would agree that providing ultrasonic images and accompanying embryonic fetal developmental information, particularly for a pregnant patient, is the standard of care in obstetrics and gynecology.

DR. THORP said it's usually done.

SENATOR WIELECHOWSKI asked if he had ever made that statement.

DR. THORP said he didn't recall making it.

2:29:19 PM
SENATOR WIELECHOWSKI asked if an ultrasound is a medically necessary procedure for a woman considering an abortion.

DR. THORP said it is a usual part of termination of pregnancy care.

SENATOR WIELECHOWSKI asked if it is usual and customary procedure in Alaska.

DR. THORP said he didn't know. He imagined there is a lot of ultrasound done in Alaska like there is in other states.

2:30:01 PM
SENATOR WIELECHOWSKI asked if he believes that providing counseling information to women considering undergoing abortion is medically necessary.

DR. THORP said it is medically necessary and ethically obligated.

SENATOR WIELECHOWSKI asked if it could potentially endanger a woman's life if counseling is not provided to a woman considering an abortion.

DR. THORP said he did not understand the question.

SENATOR WIELECHOWSKI asked if he believes that not providing counseling to a woman considering abortion would potentially endanger her life.

DR. THORP said there would be a small risk of endangerment to her life and an ethical breach of her autonomy.

2:31:24 PM
SENATOR OLSON said the questions are less than specific and, as a medical doctor, he wouldn't necessarily agree with the line of questioning. He stressed that for any procedure, a physician would have to provide information about the risks of such a procedure. He agreed that there would have to be counseling of some sort.

SENATOR WIELECHOWSKI asked if it is medically necessary to

counsel a woman about fetal pain that may occur.

DR. THORP said he didn't think doctors know enough about fetal pain to provide much counseling.

CHAIR COGHILL said he was allowing the questions in order to determine Senator Wielechowski's thinking about what is or is not a medically necessary procedure.

SENATOR WIELECHOWSKI explained that he was trying to figure out the line between what is medically necessary and what is not.

2:33:38 PM
DR. THORP asked Senator Wielechowski to define "medically necessary."

SENATOR WIELECHOWSKI asked Dr. Thorp how he defines it.

DR. THORP clarified that he has tried to define conditions that threaten the life or long-term physical health of the mother to such an extent that the state should be obliged to fund a termination of pregnancy procedure, should the mother choose that. Other than that, "medically necessary" is vague. He suggested that the bill states that physicians and patients can do whatever they want, so there are probably some less-than-life-threatening reasons why women are ending their pregnancies.

2:35:14 PM
SUSAN RUTHERFORD, MD., said she works as an OBGYN physician and in 1990 started a program in maternal fetal medicine at Evergreen Hospital. She explained that her primary role is as a practicing maternal fetal medicine specialist. She reviewed her medical credentials.

DR. RUTHERFORD said the bill is a good effort and helpful in establishing medical necessity. She opined that most doctors would generally agree about what is medically necessary. The statistics quoted about the rarity of "medical necessity" are valid, but it's mostly the patient's choice. She said patients all come with a medical history and it's rare to see a patient with a history of an abortion that was medically necessary. She said she has only seen one person in 30 years who medically required an abortion.

2:39:48 PM
DR. RUTHERFORD agreed with the list of conditions when a medically necessary abortion is warranted. She suggested, from a medical standpoint, that some of the items be reordered. Such

as, she would put epilepsy and seizures with convulsions. She said she would add a maternal history of myocardial infarction and gestational trophoblastic disease, an abnormal pregnancy situation. She noted that kidney infections are common during pregnancy, but shouldn't be on the list.

DR. RUTHERFORD addressed several subjects Dr. Thorp mentioned during his presentation. Regarding trauma, she said that it is unwise to add abortion to a patient who is unstable due to major trauma. She opined that an ultrasound is absolutely indicated prior to an abortion. A trans-vaginal ultrasound should be used when a regular ultrasound does not work. She opined that fetal abnormalities could be added to the list.

She noted that she does not perform pregnancy terminations.

2:42:57 PM
CHAIR COGHILL said he would take her suggestions seriously.

2:43:30 PM
SENATOR WIELECHOWSKI asked Dr. Rutherford if she wrote an article that stated abortion is linked to an increase in risk of breast cancer.

DR. RUTHERFORD said she didn't write any articles on breast cancer, but she believes there is evidence to that effect. The idea should not be summarily dismissed because that question has not been answered yet.

SENATOR WIELECHOWSKI asked if she disagrees with the evidence from the National Institute of Health and the National Cancer Institute that state just the opposite.

DR. RUTHERFORD said she listened to Dr. Coleman's testimony and agreed that there are flaws in medical literature, physician statements by national organizations, and state laws. She stated that she disagrees with the statement that there is no link between abortion and breast cancer.

SENATOR OLSON asked if she agrees that somebody with a kidney infection who is becoming septic needs to be treated.

DR. RUTHERFORD said yes; sepsis needs to be treated and someone who is pregnant is more prone to pulmonary edema and acute respiratory distress syndrome. She suggested adding to the list sever infection, including sepsis, exacerbated by pregnancy.

SENATOR OLSON asked about adding disseminated intravascular

coagulopathy (DIC) related to eclampsia or preeclampsia.

DR. RUTHERFORD agreed that DIC could be added to the list.

2:48:28 PM
SENATOR DYSON asked Dr. Rutherford if she has dealt with any pregnant women who had a terminal disease and opted not to abort.

DR. RUTHERFORD said she recalled one instance, but noted there are treatments for cancer during pregnancy. She suggested that the items on the list be discussed with the patient for consideration and should not automatically result in a termination. There are exceptions to many of these situations, such as those with epilepsy and treatable cancer. She said she hasn't been personally involved with a pregnancy where the mother has a terminal disease; it's extremely rare.

CHAIR COGHILL thanked the participants. He noted public testimony would continue on Monday.

CHAIR COGHILL held SB 49 in committee.

28th Legislature (2013-2014)
Committee Minutes
HOUSE JUDICIARY
Mar 29, 2013

HB 173-RESTRICT MEDICAID PAYMENT FOR ABORTIONS

1:11:02 PM

[Contains discussion of SB 49]

CHAIR KELLER announced that the only order of business would be HOUSE BILL NO. 173, "An Act defining 'medically necessary abortion' for purposes of making payments under the state Medicaid program."

1:12:17 PM

REPRESENTATIVE LEDOUX, speaking as the sponsor of HB 173 which is identical to SB 49, explained that she introduced HB 173 because she believes there should be a definition of a "medically necessary abortion." She characterized HB 173 as a fiscal bill not one of pro-life or pro-choice. She questioned why state dollars should be spent on a procedure that isn't health or life threatening. The bill, she opined, would bring clarity to a previously [undefined] term.

* * *

1:30:30 PM

REPRESENTATIVE GRUENBERG noted the list seems to include strictly physical ailments while any medical condition that could potentially, because of depression, be life threatening is absent. He then inquired as to Dr. Rutherford's opinion on adding something concerning the mental health of the mother, particularly if it can be shown there is a high likelihood that death could result if the pregnancy weren't terminated.

DR. RUTHERFORD informed the committee that for the treatment of depression during pregnancy, antidepressants are used as the risk to the fetus is miniscule. She highlighted that untreated depression can be dangerous whether the woman is pregnant or not because the pregnancy specifically is not the reason for a clinical depression requiring medication. She recalled a Senate hearing on the companion bill during which Dr. Coleman presented her research conclusions, which are the same as other

researchers around the world, that termination of a pregnancy actually worsens the mental health status of the mother. Although she acknowledged that one could find folks arguing the other side, the evidence seems to be leaning toward [the finding] that abortion will only worsen the situation. Dr. Rutherford highlighted that the list in HB 173 includes an "other" category. She then suggested that having the opinion of an expert who treats high risk pregnancies prior to the approval [of an abortion] would be a reasonable approach. In further response to Representative Gruenberg, Dr. Rutherford confirmed that she is suggesting that if there is evidence [of mental illness, an abortion] should be determined on a case-by-case basis through expert examination and testimony.

1:33:37 PM

MR. HUTCHISON explained that that there has been a definition of "medically necessary," although no one has actually clarified what it means. The 2001 Planned Parenthood of Alaska decision didn't provide a clear answer either. He noted that he would ensure that committee members' had the packet Senate members' had to provide context for the bill. The statutory foundation of HB 173 is taken from the federal Hyde Amendment, which is a rider on the federal appropriations bill regarding the limitation of federal funds for abortions. The most recent executive order addressing the Hyde Amendment was attached to the Patient Protection and Affordable Care Act in 2010. According to President Obama, "It is necessary to establish an adequate enforcement mechanism to ensure that federal funds are not used for abortion services, except in cases of rape or incest or when life of a woman will be endangered consistent with the longstanding federal statutory restriction that is commonly known as the Hyde Amendment." Therefore, any bill proposed has to include the aforementioned foundational standards such that exceptions for situations of rape, incest, and when the pregnancy threatens the life of the mother.

1:36:15 PM

MR. HUTCHISON, in response to Chair Keller, informed the committee that all states except for South Dakota are in compliance with [the standards mentioned in the Patient Protection and Affordable Care Act]. Alaska, he stated, needs to base its law on the federal Hyde Amendment and the 2001 Planned Parenthood of Alaska decision as that's the legal box within which it will operate. Furthermore, the Alaska State Constitution provides added protection, according to the 2001 Planned Parenthood of Alaska case, which is incorporated in

HB 173 through the language referring to the physical health of the mother. Many of the provisions were taken directly from Alaska Supreme Court Justice Fabe's opinion, which is why they are categorized the manner in which they are in the bill. As long as the conditions are based on neutral criteria, directly related to the healthcare program, the [bill] is safe in terms of equal protection. Again, the bill only addresses medically necessary abortions for which payment is received by Medicaid. The [goal] is to determine the difference between elective abortions and medically necessary abortions as the sponsor has reasonable belief that both are now being [processed and paid for by Medicaid] under the current definition of medically necessary. However, elective procedures aren't supposed to be covered by Medicaid. [Senator Coghill], he related, further believes that a large portion of abortions are purely elective. Mr. Hutchison clarified that Medicaid doesn't cover elective procedures, including elective abortions. Medicaid, however, is required to fund medically necessary procedures including medically necessary abortions. The problem, he stressed, is the lack of knowledge/understanding as to what's a truly medically necessary abortion under the existing legal standards.

* * *

2:06:56 PM

CHAIR KELLER asked whether a woman could have an extreme psychological condition for which a doctor could prescribe an abortion. He further asked what conditions a doctor could use in legal language to justify an abortion if the doctor determines the psychological element is sufficient enough to endanger the life of the woman.

MR. HUTCHISON offered his and Senator Coghill's belief that mental and psychological conditions shouldn't be included in the definition of medically necessary. The aforementioned is based on testimony in the Senate from expert witnesses who have stated that mental and psychological issues shouldn't be included in the definition for a medically necessary abortion.

REPRESENTATIVE LEDOUX recalled that Dr. Rutherford's testimony stated that there is research with respect to depression that an abortion would exacerbate the [depression].

MR. HUTCHISON concurred and added that the Senate heard testimony from Dr. Coleman regarding her studies on that issue.
[HB 173 was held over.]

28th Legislature(2013-2014)
Committee Minutes
SENATE FINANCE
Mar 29, 2013

SENATE BILL NO. 49

"An Act defining 'medically necessary abortion' for purposes of making payments under the state Medicaid program."

9:09:42 AM

SENATOR JOHN COGHILL, introduced SB 49, and referred to the Sponsor Statement (copy on file).

> Senate Bill 49 specifically brings clarity to the term "medically necessary abortion" for the purposes of making payments under Medicaid. In 2001, the Alaska Supreme Court determined the state must pay for medically necessary abortions for participants in the Medicaid program. Since 2001, the term "medically necessary abortion" has acquired a constitutional component of unknown scope. The relatively few Alaska cases involving abortion rights do not provide guidance as to how broadly the term "medically necessary abortion" is to be construed. SB 49 answers that issue. SB 49, based on recommendations and expert testimony from medical professionals, reasonably provides a neutral definition for a "medically necessary abortion." I urge you to support SB 49.

Senator Coghill stated that the Judiciary Committee had some testifiers who identified what would be "medically necessary." He stated that the Supreme Court had determined that medical terms through conversations with medical professionals on both sides of the question. The conversations with medical professionals resulted in the Judiciary Committee drafting a list that would satisfy both the Supreme Court and what would be "good medically necessary criteria." He shared that the neutral criteria was also examined from a legal perspective. He felt that the bill described what would be considered "medically necessary", but it still provided the doctors the trust to make proper decisions. He stressed that the bill's purpose was to define the physical criteria for the life, health, and wellbeing of the mother. He remarked that the bill did

not restrict abortions; but outlined the reasons that the State of Alaska would pay for the abortion. He felt that the Judiciary Committee conducted a very thorough review of the testimony from all sides of the argument. He stated that the Judiciary Committee held six hearings, and approximately 60 people testified on the bill. He shared that the last section of the bill highlighted "serious risk to the life or physical health, includes, but not limited to the serious risk to the pregnancy of the woman." He stated that the bill gave the doctor the discretion, but outlined to the patient what would be considered "medically necessary."

9:15:51 AM

Senator Coghill referred to the provision, commonly known as the Hyde Amendment, which dealt with rape and incest. He stated that the State of Alaska paid for abortions that were the result of rape or incest. He did not know of any State of Alaska funded abortions, based on the Hyde Amendment criteria. He stated that for ten years there were no Hyde Amendment funded abortions in the state. He felt that the bill outlined an adequate framework of what would be considered "medically necessary", and considered all others "elective." He felt that the framework was necessary, so whoever paid for the abortion could clearly understand the criteria.

Co-Chair Meyer stressed that the focus of the meeting should be directed toward the financial implications.

CHAD HUTCHISON, STAFF, SENATOR JOHN COGHILL, shared a brief executive summary as to the federal foundation, and the terms that were used in the bill. He stated that the definition of "medically necessary" incorporated the statutory that was outlined in the Hyde Amendment. He looked at tab 4 of the "HB 49 Committee Binder" (copy on file). The Executive Order 13535, Section 1:

> It is necessary to establish an adequate enforcement mechanism to ensure that Federal funds are not used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), consistent with a longstanding Federal statutory restriction that is commonly known as the Hyde Amendment.

Mr. Hutchison remarked that SB 49 included provisions for

rape, incest, or danger to the life of the mother. He encouraged the committee to read tab 7 for more information regarding the Hyde Amendment.

9:20:45 AM

Mr. Hutchison shared that the Alaska Constitution allowed for one extra layer of protection. He stated that the bill included provisions related to the physical health of the mother, which was more thorough that merely a life-threatening circumstance. He stressed that Medicaid did not fund elective procedures; therefore Medicaid shall not fund elective abortions. He stated that Medicaid funded medically necessary procedures; therefore Medicaid would not fund medically necessary abortions. He pointed out that the definition was so unclear, that he believed that elective and medically necessary procedures had been included in the previous definition. He stressed that SB 49 outlined a proper definition of what would be considered a medically necessary abortion. He looked at tab 4a, which provided some statistical context comparing other state's provisions to Alaska's current model. He pointed to the left column of page 2, which was a report from the Guttmacher Institute that listed 32 states, plus the District of Columbia that strictly followed the federal foundational platform of life endangerment, rape, and incest. He pointed out that seventeen states had a court order or voluntary provisions to allow state funds for all or most medically necessary abortions. He explained that Alaska had been court ordered to fund those procedures. The court order was based on the 2001 Planned Parenthood decision. He looked at tab 4c, page 16:

> The State, having undertaken to provide health care for poor Alaskans, must adhere to neutral criteria in distributing that care. It may not deny medically necessary services to eligible individuals based on criteria unrelated to the purposes of the public health care program.

* * *

10:04:16 AM

DOCTOR JOHN THORP, PHYSICIAN, UNIVERSITY OF NORTH CAROLINA (via teleconference), shared that he helped Senator Coghill helped define "medically necessary abortion" in the

drafting of the bill. He felt that the list was adequate in determining what was "medically necessary."

* * *

SPONSOR SUBSTITUTE FOR SENATE BILL NO. 49 am

"An Act relating to women's health services and defining 'medically necessary abortion' for purposes of making payments under the state Medicaid program."

HOUSE BILL NO. 173

"An Act defining 'medically necessary abortion' for purposes of making payments under the state Medicaid program."

8:02:11 AM

Co-Chair Stoltze discussed the agenda for the day.

8:03:11 AM

SENATOR JOHN COGHILL, SPONSOR, introduced himself and discussed his intent related to the bill presentation.

Senator Coghill stated that SB 49 would bring clarity to Medicaid payments for abortions. He detailed that the Alaska Supreme Court ruled that the state pay for medically necessary abortions, but a definition of medically necessary had not been provided. The bill was an attempt to define medically necessary, which would categorize abortions outside of the definition as elective. The bill addressed when a medically necessary abortion was required and looked to the physical health of the woman. He communicated that a presentation would provide further detail.

REPRESENTATIVE GABRIELLE LEDOUX, SPONSOR, introduced herself. She relayed that HB 173 was the companion bill to SB 49. She believed the term medically necessary abortion needed to be defined. She did not see the bill as pro-life or pro-choice, but only as fiscal legislation. She stated that the bill would bring clarity to a previously unknown term.

8:06:25 AM

CHAD HUTCHINSON, STAFF, SENATOR JOHN COGHILL, stated that SB 49 was about bringing clarity to the previously unknown term "medically necessary abortion." The goal was to define the term for the purpose of making payments under Medicaid. He referred to a bound document titled "SB 49 Committee Binder" (copy on file). Tabs 1 and 2 included a copy of SSSB 49 am and the sponsor statement. He clarified that the bill did not attempt to argue a prior Planned Parenthood case from 2001 (Tab 7). The sponsor acknowledged that Alaska was required to provide medically necessary services including medically necessary abortions to low-income individuals. The challenge was that no definition had been established to determine what constituted medically necessary.

Mr. Hutchinson pointed to Tab 1 and read the bill title. Section 1 of the bill had been amended on the Senate Floor. Section 2 included the definition for the term medically necessary abortion. He read from Section 2(a):

> The department may not pay for abortion services under this chapter unless the abortion services are for a medically necessary abortion or the pregnancy was the result of rape or incest. Payment may not be made for an elective abortion.

Mr. Hutchinson read from the top of page 2 pertaining to the definition of abortion:

> (2) "elective abortion" means an abortion that is not a medically necessary abortion;
>
> (3) "medically necessary abortion" means that, in a physician's objective and reasonable professional judgment after considering medically relevant factors, an abortion must be performed to avoid a treat of serious risk to the life or physical health of a woman from continuation of the woman's pregnancy;

Mr. Hutchinson relayed that the language had been taken out of the 2001 Planned Parenthood decision and was used in various forms in the Hyde Amendment.

8:10:07 AM

Mr. Hutchinson continued with Section 2(4):

> "serious risk to the life or physical health" includes, but is not limited to, a serious risk to the pregnant woman of
> (A) death; or
> (B) impairment of a major bodily function because of...

Mr. Hutchinson relayed that the various medical afflictions listed under the section had been verified by medical experts including eight Alaskan doctors and three national doctors. He noted that the physical conditions were included in the 2001 Planned Parenthood decision. He read a catchall provision in Section 2(4)(B)(xxii):

> another physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy that places the woman in danger of death or major bodily impairment if an abortion is not performed.

Mr. Hutchinson stated that death was the foundation the term "major bodily impairment" had been included as a mandatory extra protection as stipulated in the 2001 Planned Parenthood decision. He addressed Section 3 and relayed that the analysis had not been as substantive as that of the definition. He discussed the definition of medically necessary as stated in the bill. The definition incorporated the federal foundation required by the Hyde Amendment. He spoke to the importance of the Hyde Amendment and noted that it had been incorporated into Executive Order 13535 by President Obama for inclusion in the federal Affordable Care Act (Tab 3). He read from Section 1 of the executive order:

> it is necessary to establish an adequate enforcement mechanism to ensure that Federal funds are not used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), consistent with a longstanding Federal statutory restriction that is commonly known as the Hyde Amendment.

Mr. Hutchinson disputed the claim that there could be no restrictions on funding for abortions. He stated that the executive order limited abortion funding to cases involving rape, incest, and the life of the woman. He relayed that the definition in SB 49 provided more protection than the

federal definition. He read from Hyde Amendment language under Tab 4:

> Section 508 (a) The limitations established in the preceding section shall not apply to an abortion
>
> (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.

Mr. Hutchinson emphasized the word physical and relayed that the focus was incorporated into the bill's definition.

* * *

GUTTMACHER INSTITUTE

STATE POLICIES IN BRIEF

As of AUGUST 1, 2015

State Funding of Abortion Under Medicaid

BACKGROUND: First implemented in 1977, the Hyde Amendment, which currently forbids the use of federal funds for abortions except in cases of life endangerment, rape or incest, has guided public funding for abortions under the joint federal-state Medicaid programs for low-income women. At a minimum, states must cover those abortions that meet the federal exceptions. Although most states meet the requirements, one state is in violation of federal Medicaid law, because it pays for abortions only in cases of life endangerment. Some states use their own funds to pay for all or most medically necessary abortions, although most do so as a result of a specific court order.

HIGHLIGHTS:

- 32 states and the District of Columbia follow the federal standard and provide abortions in cases of life endangerment, rape and incest.
  - 3 of these states also provide state funds for abortions in cases of fetal impairment.
  - 3 of these states also provide state funds for abortions that are necessary to prevent grave, long-lasting damage to the woman's physical health.
- 1 state provides abortions only in cases of life endangerment, in apparent violation of the federal standard.
- 17 states use state funds to provide all or most medically necessary abortions.
  - 4 of these states provide such funds voluntarily.
  - 13 of these states do so pursuant to a court order.

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CONTINUED

APPENDIX D – Planned Parenthood v. Strange (3AN-14-04711CI)

STATE FUNDING OF ABORTION UNDER MEDICAID

STATE	GENERALLY FOLLOWS THE FEDERAL STANDARD, FUNDS IN CASES OF:		FUNDS ALL OR MOST MEDICALLY NECESSARY ABORTIONS
	Life Endangerment, Rape and Incest	Other Exceptions	
Alabama	X		
Alaska			Court order‡
Arizona			Court order
Arkansas	X		
California			Court order
Colorado	X		
Connecticut			Court order
Delaware	X		
Dist. of Columbia	X		
Florida	X		
Georgia	X		
Hawaii			Voluntarily
Idaho	X		
Illinois			Court order
Indiana	X	Physical health	
Iowa*	X	Fetal impairment	
Kansas	X		
Kentucky	X		
Louisiana	X		
Maine	X		
Maryland			Voluntarily
Massachusetts			Court order
Michigan	X		
Minnesota			Court order
Mississippi	X	Fetal impairment	
Missouri	X		
Montana			Court order
Nebraska	X		
Nevada	X		
New Hampshire	X		
New Jersey			Court order
New Mexico			Court order
New York			Voluntarily
North Carolina	X		
North Dakota	X		
Ohio	X		
Oklahoma	X		
Oregon			Court order
Pennsylvania	X		
Rhode Island	X		
South Carolina	X		
South Dakota	†		
Tennessee	X		
Texas	X		
Utah	X	Physical health	
Vermont			Court order
Virginia	X	Fetal impairment	
Washington			Voluntarily
West Virginia			Court order
Wisconsin	X	Physical health	
Wyoming	X		
TOTAL	32+DC		17

* The Iowa governor must approve any abortion paid for by the Medicaid program.

† State only pays for abortions when necessary to protect the woman's life.

‡ A law that defines medically necessary is temporarily blocked by a court.

APPENDIX D – Planned Parenthood v. Streur (3AN-14-04711CI)

FOR MORE INFORMATION:

For information on state legislative and policy activity, click on Guttmacher's Monthly State Update, for state-level policy information see Guttmacher's State Policies in Brief series, and for information and data on reproductive health issues, go to Guttmacher's State Center. To see state-specific reproductive health information go to Guttmacher's Data Center, and for abortion specific information click on State Facts About Abortion. To keep up with new state relevant data and analysis sign up for the State News Quarterly Listserv.

Boonstra HD, Insurance coverage of abortion: beyond the exceptions for life endangerment, rape and incest, *Guttmacher Policy Review*, 16(3):2–8.

Sonfield A and Gold RB, *Public Funding for Family Planning, Sterilization and Abortion Services, FY1980–2010*, New York: Guttmacher Institute, 2012.

Kacanek D, et al., Medicaid funding for abortion: providers' experiences with cases involving rape, incest and life endangerment, *Perspectives on Sexual and Reproductive Health*, 42(2):79–86.

Henshaw SK et al., *Restrictions on Medicaid Funding for Abortions: A Literature Review*, New York: Guttmacher Institute, 2009.

Boonstra HD, The impact of government programs on reproductive health disparities: three case studies, *Guttmacher Policy Review*, 11(3):6–12.

Sonfield A, Alrich C and Gold RB, Public funding for family planning, sterilization and abortion services, FY 1980–2006, *Occasional Report*, New York: Guttmacher Institute, 2008, No. 38.

Boonstra HD, The heart of the matter: public funding of abortion for poor women in the United States, *Guttmacher Policy Review*, 10(1):12–16.

APPENDIX D- Planned Parenthood v. Streur (SAN-14-04711C1)