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THE SUPREME COURT OF THE STATE OF ALASKA

STATE OF ALASKA, *et al.*,

Appellants,

v.

PLANNED PARENTHOOD OF THE GREAT NORTHWEST,

Appellee.

Supreme Court No. S-16123

Superior Court Case 3AN-14-04711 CI

APPEAL FROM THE SUPERIOR COURT, THIRD JUDICIAL DISTRICT, THE HONORABLE JOHN SUDDOCK PRESIDING

AMICUS CURIAE BRIEF OF ALASKA PHYSICIANS FOR MEDICAL INTEGRITY

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

Cases

TABLE OF AUTHORITIES (CONTINUED)

Page

TABLE OF AUTHORITIES (CONTINUED)

Page

Statutory Authorities

Other Authorities

PROVISIONS RELIED UPON

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 epilepcticus;

(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.

STATEMENT OF INTEREST OF THE AMICUS CURIAE

Alaskan Physicians for Medical Integrity is a group of Alaskan physicians with a multiplicity of practices and specialties who believe that integrity should be maintained within the practice of medicine in this State. Named representatives of Alaskan Physicians for Medical Integrity include: Dr. Ronald E. Christensen, Dr. Ilona J. Farr, Dr. Jason A. Lattin, Dr. Louis E. Mayer, and Dr. Frank H. Moore. Alaskan Physicians for Medical Integrity are well-credentialed and respected obstetrician/gynecologists, family practitioners, general practitioners, emergency care practitioners, and other physicians with a combined hundreds of years' experience in caring for Alaskan women, including those in indigent circumstances, Native Alaskans, single mothers, and other patients in difficult-life circumstances. As such, Amicus Curiae has a direct interest in this case.

Alaskan Physicians for Medical Integrity believe that necessary medical services that are paid for through government funding, such as Medicaid, should truly be medically necessary, consistent with medical science and accepted knowledge and practices within the medical community Alaskan Physicians for Medical Integrity believe that the definition of medical necessity for abortion, as stated in the law at issue in this case, S.B. 49, is well-grounded in medical science, knowledge, and reputable medical practice. Alaskan Physicians for Medical Integrity reject the ill-founded notion that all abortions are medically necessary simply because a woman desires the abortion.

STANDARD OF REVIEW

Amicus writes to respectfully challenge as erroneous the superior court's findings that led to its conclusion that virtually every abortion a patient desires is "medically necessary." Amicus contends, based on its members' many years of experience caring for Alaska's indigent women, that a standard of care exists for determining whether an abortion is medically necessary, and that S.B. 49 appropriately reflects this standard. This Court owes no duty of deference to the constitutional fact findings of inferior trial court judges in constitutional cases. Applying independent review, this Court should hold that SB 49 properly advances the State's interests in providing Medicaid funding to ensure that patients are not subjected to significant health risks, while also protecting the public fisc from unscrupulous providers such as the plaintiff, who inevitably find a medical basis for billing all abortion procedures to the State treasury.

This case involves both legislative and constitutional facts. Although there is a fine distinction between "legislative" and "constitutional" facts, the terms are sometimes used interchangeably by courts and legal scholars to refer to "those facts 'which assist a court in forming a judgment on a question of constitutional law'"[1]—they are those

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[1] *Varnum v. Brien,* 763 N.W.2d 862, 881 (Iowa 2009) (citing and quoting Kenneth C. Davis, *An Approach to Problems of Evidence in the Administrative Process,* 55 Harv.L.Rev. 364, 403 (1942); *A Woman's Choice-East Side Women's Clinic v. Newman,* 305 F.3d 684, 688-89 (7th Cir. 2002) (court switched from the term "legislative fact" to "constitutional fact," as if they are synonymous); *Fortin v. Darlington Little League, Inc.,* 514 F.2d 344, 348-49 (1st Cir. 1975) (same); Davis, 55 Harv. L. Rev. at 403 (refers to legislative facts as constitutional facts).

"circumstances which constitutionally either legitimate the exercise of legislative power or substantiate the rationality of the legislative product."[2]

Legislative facts, sometimes referred to as "social facts,"[3] "are patterns of social, economic, political, or scientific behavior or other data that a court inevitably uses to inform and shape the policy judgments it often has to make in deciding newly-presented questions of law."[4] Legislative facts arise when the court is called upon to "adapt[] law to a volatile social-political environment,"[5] and they "are those which help the tribunal to determine the content of law and policy and to exercise judgment or discretion in determining what course of action to take."[6] Examples of legislative fact include the expected impact of an abortion law in one state as opposed to another.[7] The instant case involves many similar questions of legislative fact such as: whether there exists a medical concept of "necessity" for ordering treatment; the comparative health risks of

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[2] *Varnum,* 763 N.W.2d at 881 (quoting 2 John W. Strong, *McCormick on Evidence* § 328 at 370 (5th ed. 1999)).

[3] *See, e.g., Brown v. Bd. of Education,* 347 U.S. 483, 494 (1954) (demonstrable social fact that racial segregation in public schools "generates a feeling of inferiority as to [African-American children's] status in the community that may affect their hearts and minds in a way unlikely to ever be undone").

[4] *Dean v. District of Colombia,* 653 A.2d 307, 322 (D.C. Ct. App. 1995) (citing *Lewis v. United States,* 408 A.2d 303, 311 n.11 (D.C. Ct. App. 1979)); Donald L. Horowitz, *The Courts and Social Policy,* 45, n.58, 275 (1977); John Monahan & Laurens Walker, *Social Authority: Obtaining, Evaluating, and Establishing Social Science in Law,* 134 U. Pa. L. Rev. 477, 482-84 (1986).

[5] *Varnum,* 763 N.W.2d at 881.

[6] *Lee v. Martinez,* 96 P.3d 291, 298 (N.M. 2004); *accord* Kenneth C. Davis, *Judicial Notice,* 55 Colum. L. Rev. 945, 952 (1955).

[7] *A Woman's Choice,* 305 F.3d at 688-89. *See also Brown,* 347 U.S. at 494 (the impact of racial segregation in education on a child's self-esteem); *In re R.M.G.,* 454 A.2d 776, 787-88 (D.C. Ct. App. 1982) (impact of cross-racial adoption on a child's sense of identity and the child's best interests); and *Fortin,* 514 F.2d at 348-49 (the "relevant physical differences between boys and girls" as related to the "boys only" structure of youth baseball).

abortion and pregnancy/child birth and the impact of indigence on availability of therapeutic abortion.

Constitutional facts are "special facts that have been deemed to have constitutional significance"[8] and that are "part and parcel of the constitutional judgment" that the appellate court is called upon to make.[9] Examples of constitutional fact include whether an abortion law will unduly burden a woman's reproductive freedom.[10] Constitutional facts, which this case involves, include: whether a cognizable line of demarcation can be drawn either judicially or legislatively between medically necessary abortions and elective abortions; the interests the State has in ensuring the integrity of the Medicaid system; and whether Medicaid-eligible women seeking abortion are similarly situated to those carrying their pregnancies to term with respect to public abortion funding.[11]

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[8] *Bose Corp. v. Consumers Union of United States, Inc.*, 466 U.S. 485, 505 (1984).

[9] *Jefferson County v. Richards*, 805 So.2d 690, 697 (Ala. 2001); *Fortin*, 514 F.2d at 348-49.

[10] *A Woman's Choice*, 305 F.3d at 689; *Women's Medical Professional Corp. v. Voinovich*, 130 F.3d 187, 192 (6th Cir. 1997). *See also generally Jacobellis v. Ohio*, 378 U.S. 184, 187-89 (1964) (whether a particular form of speech is obscene); *Ornelas v. United States*, 517 U.S. 690, 699 (1996) (whether there was reasonable suspicion to stop, and probable cause to make a warrantless search); and *McCoy v. Hearst Corp.*, 727 P.2d 711, 715 (Cal. 1986) (whether a speaker acted with actual malice).

[11] *Cf Alaska Inter-Tribal Council v. State*, 110 P.3d 947, 967 (Alaska 2005) (after conducting its own complete and independent review of the evidence in the record regarding similar situations, the court ruled that the trial court's findings were not "clearly erroneous").

For both legislative and constitutional facts, the settled standard of review[12] in a constitutional case that has long been recognized by this Court, other courts (both state and federal), and by legal scholars is *de novo* review—a review that is not limited even to the evidence in the trial court record.[13] De novo review is appropriate for legislative or constitutional fact finding because it is more akin to judicial reasoning and law making than it is to traditional fact finding.[14] It is for this reason that appellate courts are free to look outside the trial court record when they consider and determine legislative or constitutional facts.[15] When an appellate court determines legislative facts

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[12] *See State v. Planned Parenthood*, 171 P.3d 577, 581 (Alaska 2007) ("We review constitutional questions de novo, adopting the most persuasive rule of law in light of precedent, reason, and policy.").

[13] Alaska: *State v. Erickson,* 574 P.2d 1, 7 (Alaska 1978) ("we consider this evidence in evaluating the constitutional issues before us . . . [and] the court cannot be limited to the evidence presented to the trial court"); *Troyer v. State,* 614 P.2d 313, 318 (Alaska 1980) ("we have a duty to examine the entire record and make an independent determination"); *State v. Contreras,* 674 P.2d 792, 799 (Alaska Ct. App. 1983) ("questions of legislative rather than adjudicative facts" and "[c]onsequently, we are free to exercise our independent judgment"); *Sundberg v. State,* 667 P.2d 1268, 1271 (Alaska Ct. App. 1983) (court agreed with trial court that whether the police engaged in a pattern of excessive-force arrests was a question of legislative fact, which is for an appellate court rather than a trial court to determine); U.S. Sup. Ct.: *Ornelas,* 517 U.S. at 690 ("the ultimate questions of reasonable suspicion to stop and probable cause to make a warantless search should be reviewed *de novo"); Bose,* 466 U.S. at 508 ("We must 'make an independent examination of the whole record'"); *Jacobellis,* 378 U.S. at 188.

[14] *Erickson,* 574 P.2d at 5-6; *Dean,* 653 A.2d at 324-25, 327; Davis, 55 Harv. L. Rev. at 403.

[15] *Erickson,* 574 P.2d at 6-7 ("[I]n the final analysis, it is questionable whether such an expanded hearing would reveal more reliable or higher quality information than is available by referring to authorities in briefs by both sides and, in appropriate cases, by additional research at the appellate level. . . . [W]e conclude that in cases involving scientific information the court cannot be limited to the evidence presented to the trial court."); *Varnum,* 763 N.W.2d at 881 ("[C]onstitutional facts 'may be presented either formally or informally'" and they "are introduced into judicial decisions through independent research by judges and written briefs of the parties,

by considering matters outside the trial record, as this Court held was appropriate in *Erickson*, the court is conducting a de novo review.[16]

It is because legislative or constitutional fact finding is so akin to law making that appellate courts must not give deference to lower court determinations; appellate judges, as expositors of the Constitution, must independently decide whether the evidence in the record meets the requisite constitutional threshold.[17] Deference to trial courts regarding legislative or constitutional facts would subject the rule of constitutional law to the idiosyncrasies of individual trial judges and thus would threaten to defeat necessary uniformity.[18] For this reason, Amicus urges the Court to examine carefully the legislative and trial record below.

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as well as testimony of witnesses.") (citing 2 John W. Strong, *McCormick on Evidence* § 328, at 381-84 (5th ed. 1999)); *Dean,* 653 A.2d at 327 ("Legislative facts also sometimes are found exclusively in non-record sources, such as a party's 'Brandeis brief' and the judge's own research, without help from expert testimony."); *see also e.g., Brown,* 374 U.S. at 489-94; *McLean v. Arkansas,* 211 U.S. 539, 549-50 (1909).

[16] *Id.* at 7 ("We consider this evidence in evaluating the constitutional issues before us;" "the court cannot be limited to the evidence presented to the trial court"); *accord Varnum,* 763 N.W.2d at 881 ("We review all of the material tendered by the parties in this case to assist us in our review of the constitutionality of the . . . statute.").

[17] *Bose,* 466 U.S. at 510-11 and n.27; *McCoy,* 727 P.2d at 715.

[18] *Ornelas,* 517 U.S. at 697 *(de novo* review offers the greater opportunity to "unify precedent"); *Miller v. Fenton,* 474 U.S. 104, 114 (1985) *(de novo* review better serves the "sound administration of justice"); *A Woman's Choice,* 305 F.3d at 688-89 ("Constitutionality must be assessed at the level of legislative fact, rather than adjudicative fact determined by more than 650 district judges. Only treating the matter as one of legislative fact produces the nationally uniform approach. . . . [A]n issue of 'constitutional fact' is reviewed without deference in order to prevent the idiosyncracies of a single judge or jury from having far-reaching legal effects."); *State v. Weisler,* 35 A.3d 970, 979 (Vt. 2011).

STATEMENT OF THE CASE

In State of Alaska, DHSS v. Planned Parenthood of Alaska, 28 P.3d 904 (2001), this Court ruled that the State Medicaid program must fund all "medically necessary" abortions. The language employed by this Court to describe health conditions which give rise to "medically necessary procedures" (*id.* at 907) was clearly chosen to communicate that not all such conditions qualify as "necessary", and that "abortion on demand" would not be available through Medicaid. The Court used the phrases "medically necessary" or "medical necessity" thirty-seven times in its Opinion. "Some women," the Court explained, "– particularly those who suffer from pre-existing health problems – face *significant risks* if they cannot obtain abortions." *Id.* at 907 (emphasis added). The Court stated that funding would be made available for a "medically necessary procedure," where a woman's "health is endangered by pregnancy" (*id.* at 905)—*i.e.,* those women "whose health depends on obtaining abortions." *Id.*[19] The Court was pellucid in asserting that a standard must exist for publicly funded abortions:

> 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. . . ."

Id. at 905. The Court assured Alaskans that its decision did not require the funding of "elective abortions."

In order to provide guidance to State officials regarding these "significant risks," the Court referred to trial testimony regarding diabetic patients who risk kidney failure,

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[19] *See also State, DHSS*, 28 P.3d at 906, 915 ("medically required abortions"); 908 ("necessary care"); 908 ("threat to their health arising from pregnancy"); 915 ("medically necessary services").

blindness, and preeclampsia; patients with renal disease who may lose a kidney and face a lifetime of dialysis if they cannot obtain an abortion; and women with sickle cell anemia, for whom pregnancy can accelerate progress of the disease leading to pneumonia, kidney infection, pulmonary embolus (a leading cause of death in pregnancy) and congestive heart failure. *State, DHSS,* 28 P.3d at 907. The Court also cited situations in which medications for serious psychiatric conditions, such as bipolar disorder and schizophrenia, may be dangerous to a developing fetus, forcing such patients to choose between endangering their offspring or jeopardizing their own health by refraining from taking them.[20]

The Supreme Court made it clear that it did not intend to impose an obligation on the State to "provide limitless health care services to all poor Alaskans." *State, DHSS,* 28 P.3d at 910. Rather, the Court referred to the equal protection principle that "DHSS is constitutionally bound to apply neutral criteria in allocating health care benefits, even if considerations of expense, medical feasibility, or the necessity of particular services otherwise limit the health care it provides to poor Alaskans." *Id.*, citing *Shapiro v*

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[20] The Supreme Court added to this litany an observation regarding financial constraints:

> 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.

State, DHSS, 28 P.3d at 907. Nonetheless, because financial distress alone does not qualify patients for otherwise unavailable Medicaid funding, this statement is best viewed as an expression of concern about the particular risks that lack of funding can impose on indigent women who would otherwise qualify for a medically necessary abortion procedure, and not a separate basis for establishing medical necessity.

Thompson, 394 U.S. 618, 633 (1969) ("We recognize that the State has a valid interest in preserving the fiscal integrity of its programs. It may legitimately attempt to limit its expenditures, whether for public assistance, public education, or any other program. But a State may not accomplish such a purpose by invidious distinctions between classes of citizens."). The Court concluded that DHSS provided "necessary medical care to all Medicaid-eligible Alaskans except women who medically require abortions," and that "[t]his differential treatment lacks a fair and substantial relation to the object of the Medicaid program, and therefore violates equal protection." *Id.* at 911.

State, DHSS involved the total exclusion of abortion from State Medicaid funding. Where, as here, the State administers a neutral rule that pays for "medically necessary" services, and only necessary services, it does not treat different classes of citizens or patients differently, and the equal-protection doctrine is inapplicable. For example, the Court acknowledged in *State, DHSS* that Medicaid exclusions for medically unnecessary inpatient treatment, beautifying cosmetic surgery, and most organ transplants would "appear to relate to medical necessity, cost and feasibility—all politically neutral criteria." *State, DHSS*, 28 P.3d at 910.

Planned Parenthood now contends that the State's attempt to draw the line of demarcation approved by this Court's prior decision must fail because, in essence, *all* abortion procedures its physicians find indicated for a patient are "medically necessary." The lower court embraced Planned Parenthood's reasoning wholesale, ruling that "application of any rigid standard" is "impractical." *Planned Parenthood v Streur,* Decision and Order dated Aug. 27, 2015 *("Streur")* at 52. "This ruling, if upheld,

means as a practical matter that virtually all indigent Alaskan women seeking abortions will receive state Medicaid funding." *Streur* at 52-53. For the reasons set forth herein, Amicus respectfully disagrees. As with all medical procedures, there is a proper and discernible distinction between procedures that are necessary to preserve a patient's life and health and those that are undertaken voluntarily to achieve a speculative or subjectively desired result. S.B. 49, as authoritatively construed by the Law Department, adequately delineates that distinction, and consequently should be upheld by this Court. Although the State could not assert an interest that was sufficiently compelling to withhold Medicaid funding for medically necessary abortions in *State, DHSS*, 28 P.3d at 913, its interest in neutrally administering the Medicaid program by paying only for medically "necessary" services—either on behalf of patients who carry their pregnancy to term and deliver, or on behalf of those who choose to terminate their pregnancy—passes muster under the standard set forth by the Court.

The Trial Court's Decision.

As State's counsel explained to the trial court, "the line that this legislation draws [is that] Medicaid will cover an abortion if pregnancy poses a serious risk to your health but not an abortion solely to protect her emotional well-being." Transcript of Trial ("Tr.") at 16:3-6. As such, the trial court's conclusion that the statute and regulation "eliminate funding for most medically necessary abortions" (*Streur* at 1) was erroneous. The Court reasoned that the parties' divergent readings "suggest a lack of clarity in the statute." *Streur* at 29. While it found the statute "susceptible to both interpretations," and in spite of the State's clear articulation of a reasonable middle ground focused on

avoiding risks that pose serious threats to maternal health, the court stated it was convinced that the legislature intended the provision as a "high-risk, high hazard standard that would preclude funding for most Medicaid abortions." *Id.*

The court well-recognized that plaintiff's experts testified that all pregnancies entail a risk that a serious risk will arise, *Streur* at 30, and it appears to have accepted that assertion at face value. "Simply put, an unwanted pregnancy is a crisis for any woman," Judge Suddock reasoned. *Streur* at 38. To Planned Parenthood's 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." *Streur* at 43.[21] Contrary to extensive testimony that "medical necessity" is a concept that is commonly employed in treating patients and seeking third-party reimbursement, the court characterized it as a term "mainly used in the insurance industry to deny claims," and instead substituted the concept of "medically indicated." *Streur* at 10-11.

Without addressing the political positions of plaintiff's testifying experts or discounting Planned Parenthood's own abortion providers based on their obvious financial motivation to set a low bar for Medicaid eligibility, the court derided the

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[21] "Presumably Minnesota abortion providers are as inclined to discern medical necessity as Alaskan providers, who have apparently never failed to do so," the court stated. *Streur* at 50, citing *Women of State of Minn. by Doe v. Gomez*, 542 N.W.2d 17 (Minn. 1995). This is undoubtedly true, insofar as fully 40 percent of all abortions in the State of Minnesota are paid for by Medicaid. *See* Minnesota Department of Human Services, *Induced Abortions in Minnesota January – December 2014: Report to the Legislature* (July 2015) at 3 (Table 1.1 noting 10,123 total abortions in 2014); 19 (Table 16 noting 3,858 abortions paid by public assistance). Of the reasons provided for abortion, 2,712 women cited "economic reasons," 6,998 cited "do not want children at this time," and 747 stated "emotional health is at stake." (Some respondents gave more than one answer.) Table 17 at 20. Available at www.health.state.mn.us/divs/chs/abrpt/2014abrpt.pdf (cached).

State's trial experts as "self-identified pro-life advocates." *Streur* at 41. The court criticized the legislative testimony of Dr. Coleman that an abortion uniformly worsens a woman's mental health, or can itself trigger mental illness, as a "canard." *Streur* at 37. He called Psychiatrist Dr. Eileen Ryan's testimony "dogmatic," and charged that "[a]melioration of mental suffering via an abortion is not medically necessary [to her] because this would contradict her personal moral standards." *Streur* at 39. Judge Suddock likewise dismissed Dr. Steve Calvin's testimony for the State as an "ipse dixit," a high-risk standard that "accords with his personal religious precepts against abortion." *Streur* at 38. Judge Suddock's fact findings in this regard reflect nothing more than his personal socio-political predilections and favor for abortion, and most certainly not medical science; as such, these findings do not warrant deference from this Court.

Having rejected the "straw man" reading of the statute that imposed a "high risk" interpretation (a standard the State neither urged nor desires), the court went on to attempt to define a constitutional standard. *Streur* at 41. It found such a standard in the decisions of other states allowing Medicaid funding for all abortions relating to "health," and 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.

Streur at 42. "For all practical purposes, [these standards] empower a physician to certify virtually any pregnancy as medically necessary within the physician's

discretion," the court concluded. *Streur* at 51. The court completely rejected the understanding that undergirded this Court's prior decision, that a medical line may be drawn at abortions that are not "medically necessary"—the court rejected this Court's assurance that the State was not required to pay for elective abortions:

> 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 involuntary assumption of significant risks on those forced by circumstance to carry to term.

Streur at 52. "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," Judge Suddock reasoned. *Id.*

ARGUMENT

I. THE SUPREME COURT'S DECISION IN *STATE OF ALASKA, DHSS v. PLANNED PARENTHOOD OF ALASKA* ESTABLISHED AS A MATTER OF LAW THAT DHSS COULD RELY ON "NEUTRAL CRITERIA" TO DETERMINE WHETHER AN ABORTION PROCEDURE WAS "MEDICALLY NECESSARY" AND THUS REIMBURSABLE UNDER MEDICAID.

As this Court found in *State, DHSS*, the constitutional key to distinguishing between "elective abortions" that the State is not obligated to fund, and "medically necessary" abortions that the State is obligated to fund, is the use of "neutral criteria." The Court has already recognized "medical necessity" as being a "neutral criterion." *Id.* at 910. Thus, the distinction between "medically necessary" care and "non-medically necessary" care is a constitutionally "neutral distinction." If the criteria for distinguishing between what the State must fund and need not fund must be "neutral," then the terms and concepts used in drawing that distinction must likewise be "neutral."

Medical necessity is a neutral medical concept. Thus, drawing a distinction between "medical necessity" and "election" with respect to abortion using accepted medical terms and concepts should likewise be constitutionally neutral. So long as the State defines the difference between "medically necessary" abortion and "elective" abortion using accepted medical knowledge, practice, terms and concepts, there is no constitutional infirmity in the State's action in adopting such a definition for purposes of funding "medically necessary" abortions.

The State is not obligated to leave the definition of "medical necessity" for purposes of Medicaid funding in the sole and unquestioned discretion of the physician. If that were the case, then the State would not be permitted to define the types of medical care that are covered by Medicaid and the types of medical care that are not. But the Alaska Supreme Court plainly indicated that it was permissible for the State to draw such a distinction independent of the physician. *See id.* at 910 (unnecessary inpatient treatment and beautifying cosmetic surgery). Moreover, the trial court in this case ignored extensive testimony establishing that *all* Medicaid procedures are subject to review for medical necessity pursuant to neutral and objective criteria.[22]

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[22] *See* Tr. at 546 (testimony of Jonathan Sherwood, Deputy Commissioner for Medicaid, regarding federal requirements that Medicaid pay for services that are medically necessary); Tr. at 558 (providers are required to document the medical necessity and keep that in the clinical record); Tr. at 547-48 (orthodonture to correct a medical condition that would have adverse health consequences is paid for, but not to improve general appearance; "[t]hat standard would be unmanageable because somebody could always make the case they would feel better or experience subjective improvement as a result of treatment."); Tr. at 628-29 (testimony of Cindy Christensen, Health Program Manager DHSS, Division of Healthcare Services, to the same effect re botox); Tr. at 595-622 (Christensen: Medicaid will only pay for medically necessary hysterectomy or sterilization; dental services beyond a threshold amount; mastectomies

II. THE SUPERIOR COURT ERRED IN IGNORING THE OVERWHELMING WEIGHT OF THE EVIDENCE ADDUCED AT TRIAL THAT DEMONSTRATED THAT S.B. 49 REFLECTS A MEDICALLY UTILIZED AND DISCERNIBLE SET OF NEUTRAL CRITERIA FOR DETERMINING WHETHER TO RECOMMEND AN ABORTION AS "MEDICALLY NECESSARY."

Planned Parenthood is the only institutional provider of abortion in the State of Alaska. Testimony by Planned Parenthood's part-time, abortion-providing physicians and medical witnesses demonstrated that, for purposes of its own practice, no concept of an "elective abortion" is recognized—all abortions, for whatever reason, are regarded as "medically indicated," frequently for idiosyncratic reasons, and thus "medically necessary." But this is not the standard of practice outside the four walls of a Planned Parenthood facility. The overwhelming testimony, both of plaintiff's and the State's expert witnesses, established that abortion is rarely recommended as a treatment option, and only discussed when raised by a patient. Even Planned Parenthood's expert physicians acknowledged that in their own practice they recognize a concept of "medical necessity" with regard to abortion and refer to it in order to draw a line of demarcation between an abortion they would regard as "necessary" and one that is truly "elective." Viewed in its entirety, the trial testimony establishes beyond argument that providers can and do draw a line between therapeutic and genuinely volitional abortions, and the superior court erred in blinding itself to that fact.

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are subject to prior authorization (619-20); and Medicaid does not pay for fertility treatments (622)).

A. The Superior Court Erred by Crediting Plaintiff's Evidence and Argument that Virtually Every Abortion is "Medically Necessary" as a Matter of Constitutional Fact.

1. The Evidence at Trial Established that Planned Parenthood Refuses to Acknowledge the Existence of a Concept of "Medical Necessity" When it Comes to Abortion.

In 2014, Planned Parenthood performed 1,410 abortions on Alaskan women. Tr. at 129:24-130:4 (Testimony of Rebecca Poedy, Chief Operating Officer, PPGNW). Of that number, 474—or just over a third—were paid for by Medicaid. Tr. at 150:8-151:4 (Poedy). It thus appears that every Medicaid-eligible, Planned Parenthood patient has her abortion paid for by the Alaska treasury as allegedly being "medically necessary." As Dr. Whitefield has testified previously in the parental consent litigation, over his entire career, he has only failed to find medical necessity for ten women who lacked private funding for their abortion. *See* Appendix A (trial testimony of Dr. Jan Whitefield in *Planned Parenthood*, 177 P.3d 577). Dr. Whitefield finds medical necessity for an abortion when a woman finds her pregnancy to be an "affront" to her—meaning simply that she does not want to be pregnant, perhaps simply to avoid work or educational inconvenience. *Id.*

Dr. Eric Lantzman, who performs abortions for Planned Parenthood on a contract basis, testified that Planned Parenthood utilizes a "guidance document" ostensibly to assess whether an abortion is Medicaid-eligible. Tr. at 407:19-408:7 (Testimony of Dr. Eric Lantzman); Tr. at 402:17-18 (Lantzman); Trial Ex. 18. Planned Parenthood's general, standard practice conforms to Dr. Whitefield's practice. Lantzman testified that the guidance document seeks reasons why the patient is terminating the pregnancy,

including "health conditions that would be impacted by a pregnancy," but also reasons that "relate to their education or career needs, age, existing family responsibilities, fear of physical or emotional abuse by a boyfriend/husband/parent or substance abuse." In response to the question, "[W]hy were these particular reasons included in the guidance?," Lantzman referred back to the subjective motivations of patients, stating: "These are some of the things that we commonly hear that are – appear to be affecting the health and well-being of our patients and are motivations for decision-making." Tr. at 408:3-7.

In practice, Planned Parenthood physicians deem every abortion "medically necessary." They do so by employing a definition akin to Judge Tan's—an abortion is "necessary" if it will "ameliorate a condition harmful to a woman's physical or psychological health." Tr. at 400:16-23. Planned Parenthood's "guidance" incorporates the language of the U.S. Supreme Court's companion case to *Roe v. Wade*, *Doe v. Bolton*, 410 U.S. 179 (1973), that defined what "health of the mother" means for purposes of allowing abortion through all nine months of pregnancy (Tr. at 404:24-405:11):

> Again, this is trying to help guide our physicians to feel comfortable using their clinical judgment and respecting how an individual's pregnancy can affect all of the physical, emotional, psychological, familial and age-related factors for an individual.

Tr. 405:13-17 (Lantzman).

Dr. Lantzman has a brief two-to-ten-minute conversation with patients seeking Medicaid reimbursement[23] (Tr. at 422:22-423:3) in which he advises the patient that Alaska requires there be a reason for the abortion that qualifies under Medicaid. Tr. at 406:11-23. Based on that conversation, he checks a box on the Medicaid abortion claim form. Tr. at 406:22-407:3. For one-third of his Medicaid patients at Planned Parenthood, Dr. Lantzman determines they have a physical condition that renders the abortion "necessary." Tr. at 409:5. Two-thirds thus relate to non-somatic conditions. Although Lantzman is aware that submitting a bill to Medicaid is an implicit certification that the procedure was medically necessary, Tr. 457:2-6, he acknowledged that is it impossible to tell from a patient chart why an abortion was thought necessary. Tr. 448:12-16; Ex. E, redacted patient chart. In fact, Lantzman admitted, no documentation submitted with request for reimbursement documents the basis for the physician's determination that an abortion was medically necessary. Tr. 449:18-23.

Lantzman has never concluded that abortion was not medically necessary for a Planned Parenthood Medicaid-eligible patient. Tr. at 422:2-5. For example, Lantzman has determined medical justification for patients who expressed concern they couldn't financially support another child. Tr. at 415:7-12. Any negative psychological impact from a pregnancy, he stated, could make an abortion medically necessary. Tr. 451:11-14. Planned Parenthood contract abortion provider Dr. Jan Whitefield stated that whether aborting a Down's syndrome baby is "medically necessary" would be "determined within the framework of the patient." Tr. 530:7-8. And, again, Whitefield

[23] Lantzman does not discuss whether the abortion is medically indicated with patients who have means of payment. Tr. at 413:7-13 (statements by plaintiff's counsel).

certifies medical necessity virtually every time a woman lacks private funds and perhaps simply thinks the pregnancy will interfere with her work or educational plans.

Dr. Aaron Caughey, testifying in support of Planned Parenthood, claimed that any circumstances could make an abortion "necessary." Tr. at 78:14-23. These included physical conditions, such as renal disease (Tr. at 103:5-9), diabetes and heart disease (Tr. at 102:11-24), but also highly subjective non-somatic circumstances, such as having a night job; taking care of a special needs child; one's housing situation (Tr. 79:14-25); family obligations or the size of her family; having "a kid with special healthcare needs" (Tr. at 91:3-13) or her "socioeconomic situation" (Tr. 81:23-82:1) could make her abortion "necessary" in his mind. Tr. 80:18-20. Caughey admitted that even having an abortion for the sake of one's career could be "medically necessary:"

> Q: If a woman wanted to terminate her pregnancy because she believed that having a child would interfere with her career, would you consider that to be a medically-necessary abortion?
> A: I think it depends on whether or not, you know, in that kind of theor – hypothetical situation what the whole entire constellation of the situation was to the patient.

Tr. at 106:14-25. Ultimately, under the definition of "medically necessary" recognized by Planned Parenthood, Dr. Whitefield, Dr. Lantzman, and Dr. Caughey, all abortions could be "medically indicated" because all avoid the risk of carrying an infant to term. Tr. 108:14-109:9 ("I think if a patient said the reason that I'm having – I would like to end my pregnancy is I'm concerned about the risks of the pregnancy itself and the risk

of, you know, going through childbirth and the risk that connotes to me, then it would [be] medically indicated.").[24]

2. Planned Parenthood's Part-Time Abortion Providers and Experts Testified that at Planned Parenthood, It Is Often the Patient, Not the Physician, Who Determines Whether an Abortion is Regarded as "Necessary."

Even though plaintiff's experts claimed that therapeutic decisions are often complex, multi-faceted ones that require physicians to consider numerous factors, such as social and familial circumstances, financial circumstances, cultural and personal values, in addition to physiological factors, they readily acknowledged that a patient's personal choice whether to terminate the pregnancy or continue and deliver the baby predominates over all other factors, including medical ones. In fact, where a woman's desire to keep her child was known to the physician, *the question of abortion was not even raised.*

Planned Parenthood contract physician Jan Whitefield testified that while he has had "many" diabetic patients who were pregnant (Tr. 518:22-24), he wouldn't suggest she terminate the pregnancy, "unless the patient said, I'd like to think about a

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[24] Planned Parenthood's experts were permitted to provide their opinion on the legal interpretation of S.B. 49, and their views tended to the extreme. *See, e.g.*, Tr. 85:4-7 (Caughey: "It's really only in the setting where someone is about to die or is about to suffer severe injury, such as, you know, being on dialysis or being in a diabetic ketoacidosis."); Tr. 62:5-21 (Caughey); Tr. 74:5-11 ("Oh, no, no, because it's very clear. It says, including a life-endangering physical condition that places the woman in danger of death or major bodily impairment. . . ."). At times, their opinions veered into the political realm. *See, e.g.*, Tr. 92:2 (Caughey: "it's a pretty big intrusion trying to draw a line where something is medically indicated or not I think through – through kind of statutes and regulations"); Tr. 92:18-20 (Caughey: "changing laws or creating rules so that people don't even know what freedoms and options have been taken away from them").

termination." Tr. 519:7-10. It is the patient's subjective decision regarding her circumstances that control whether an abortion "indication" results in deeming the abortion "necessary:"

> A: The – the – the medical necessity – the indicate – the indication is – is caused by the pregnancy and the surrounding events, whether it be physical or psychological health. And – and if the patient wants to carry the pregnancy, that's fine. If they decide they don't want to carry the pregnancy within this context or framework that you're describing, they still would have an indication for having a pregnancy termination. It would be there. She just may not exercise it.

Tr. 532:12-20.

Planned Parenthood's Dr. Lantzman testified that in his practice at Alaska Native Medical Center, which does not provide abortions, he has "lots of patients, especially at the Alaska Native Medical Center, who have these conditions but choose to carry a pregnancy. . . ." In those cases, he agreed, the concept of "medically indicated" is "semantic"—"the patient is free to go forward to term." Tr. 410:11-20. Asked whether any level of obesity would be enough to make an abortion medically necessary, Lantzman responded:" "If the patient is concerned about that, I think that there's a medical justification for it." Tr. 443:11-14.

Dr. Caughey likewise admitted that a woman in "poor general health" could choose to have an eighth child: "That would be up to her." Tr. 116:10-17. With respect to fetal anomaly, Caughey testified that he never recommends abortion:

> Q: Do you draw a line along the spectrum of fetal anomaly between a[n] elective and a medically-necessary abortion?"
> A: In our practices, both of the practices I was a part of in San Francisco and the one I'm a part of in Portland, we don't draw that line. . . . The moment I say to that woman I recommend you end this pregnancy, it invalidates her choice. And so we – we don't actually come down so hard

> where we would recommend that they all be terminated personally in our practice.

Tr. 120:22-24; 121:23-122:16.

Dr. Renee Bibault, a psychiatrist testifying for Planned Parenthood, stated that when she initiated the conversation with a patient about termination, "often women were thinking about this anyway, but . . . they felt like they needed somebody else to – to sort of give them permission to consider it as an option." Tr. 217:21-218:8. Dr. Samantha Metzer-Brody, a psychiatrist specializing in women's reproductive mood disorders, admitted that if a patient with a mental disorder wanted to keep her pregnancy, Metzer-Brody would not even mention abortion as an option except in an acute life-threatening situation. Tr. 305:11-17:

> Q: When you discuss abortion as an option with a patient, how does it come up?
> A: In my work with – with the people we're talking about in all of these cases . . . in all of these cases, the patient has raised it as an avenue they would like to pursue.
> Q: And why don't you raise it affirmatively?
> A Because it is such a polarizing, political issue in this country, despite it being legal, that I feel that it is best if the woman brings it up and comes to me with that as a consideration.
> Q: And that's true even if you think that an abortion might be an appropriate treatment for a particular woman?
> A: Again, because of the nature of abortion and the fact that it is so polarizing and political in the United States, I feel that it is best if the woman brings it up.

Tr. 280:1-25. Clearly, the weight of testimony at trial established that both Planned Parenthood and its experts regard abortion as a "choice" in normal circumstances. If the patient chose not to consider it, it was not regarded as "medically indicated."

B. The Superior Court Erred By Disregarding the Overwhelming Weight of Evidence that the Standard of Practice for Physicians Providing Abortions and Referrals is to Recommend Abortion as "Medically Necessary" When the Patient Faces a Significant Risk of a Serious Health Condition, Such as Those Enumerated in S.B. 49.

Plaintiff's abortion providers and testifying experts admitted that they recognize and utilize a standard for "medical necessity" that is substantially higher than Planned Parenthood's illusory "standard." In direct opposition to plaintiff's assertion that "medically necessary" is a term for insurance companies, Dr. Samantha Metzer-Brody readily acknowledged that she does, in fact, use the term in her practice, and referred to a definition of "medically necessary" that is more rigorous than that utilized by Planned Parenthood:

> Q: Do you use the term medically necessary in your practice?
> A: Yes.
> Q: And in what context?
> A: So as physicians, we are trained to diagnosis and to the best of our knowledge provide treatment that will be in the best interest of the patient's health. As such, when we make treatment recommendations, in general, we would like them to be considered medically necessary or . . . in our position as physicians prescribing medical care.
> Q: How do you define a medically-necessary abortion?
> A: As a psychiatrist who sees women with mental health issues in the perinatal period, I would say that I define a medically-necessary abortion as an abortion that is medically indicated to preserve the woman's mental health and is in the best interest of the woman's mental health.

Tr. 256:5-20. Metzer-Brody testified that she had only "five or six cases" over two years where abortion resulted in a "significant improvement" in the patient's mental health; "in all cases, these women were extremely depressed with horrible symptoms of anxiety and active suicidal ideation, and it was felt that the only way to relieve the overwhelming symptoms would be to end the pregnancy; and this was made in very

close consultation with the patient, her family, the OB/GYN team and the psychiatry team with extensive team meetings that included the – the patient and family." Tr. 262:1-19.

Planned Parenthood's expert Dr. Caughey not only recognized the existence of a non-"necessary" abortion, he drew a line at certain abortions:

> Q: You do recognize that there is something that could fairly be categorized as an elective abortion?
> A: I think that Ms. Paton-Walsh delineating someone who might be so frivolous as to not really consider the implications of the healthy out – implication of the pregnancy and just might view it as an inconvenience, that – I assume that situation does exist somewhere.

Tr. 122:25-123:6.

> Q: But I think I heard you say that you consider pregnancy deferment for career purposes medically necessary or not?
> A: I think I said, no, if that was the only reason.

Tr. 123:14-16.

Similarly, Dr. Sharon Smith, a family medicine physician practicing at a community health center who does not provide abortions (Tr. 320:17-18) and whose clinic does not provide abortions (Tr. 321:16-17), testified that she had counseled a woman from a different culture who wanted an ultrasound to determine whether she was carrying a girl, in which case she would abort the child. "I told her I was not comfortable caring for her, that that was not an acceptable reason for having an abortion and that she would need to find another doctor." "[A sex-selection abortion is] not a medically-necessary abortion," she flatly stated. Tr. 375:4-376:9; *cf.* Tr. 384:10-12 ("You draw a line at sex selection, yes? A. I do."). Under voir dire by the court, Smith also admitted that the absence of a left hand would not make an abortion medically

necessary. Tr. 385:1-5. These admissions came in spite of her testimony in deposition describing the concept of elective abortion as a "fantasy." Tr. 378:5-13.

Outside of Planned Parenthood, the standard of practice does not reflect Planned Parenthood's default mode of characterizing every abortion as "necessary." For example, plaintiff's expert Smith has never had a patient for whom she considered an abortion to be medically necessary because of substance abuse, Tr. 356:22-25, or to whom she suggested abortion as an option because of the health condition her patient was in. Tr. 374:17-20. Plaintiff's expert Dr. Metzer-Brody stated that of the "thousands" of pregnant women she has treated in her career, she has had a conversation about whether to terminate the pregnancies with only "a relatively small percentage of women." Tr. 252:20-253:1.

Planned Parenthood's expert Dr. Bibault has only advised three to five individuals to have an abortion to protect their mental health, Tr. 237:5-11, and even in those, she only "presented it as an option." Tr. 236:16-24. Dr. Bibault clearly expressed a higher standard for "medically necessary" abortions than Planned Parenthood's when she testified:

> Q: Well, will you give me your full definition again of when something's clinically indicated.
> A: I would say something's clinically indicated when there's a *high likelihood* that it's going to help to diagnose or treat a mental disorder, relieve clinically significant distress, *is considered relatively safe*, and is *supported, when possible, by the available scientific literature or accepted standards of practice*.

Tr. 239:15-22 (emphases added); *see also* Tr. 192:6-12 ("I think an abortion would be clinically indicated or warranted when ending the pregnancy state has a *high likelihood*

of improving symptoms due to a psychiatric illness or a *high likelihood of removing the* complications – removing barriers to treatment."). For women who did not meet the full DSM-5 criteria for diagnosis of a psychiatric condition, Bibault found an abortion clinically indicated where "there was a great deal of distress and suffering and often a decline in functioning, and based on all factors and my clinical experience and my discussion with the woman, it seemed like ending the pregnancy state would improve that." Tr. 211:1-7.

Dr. Smith testified for plaintiff that "I don't have a lot of patients who seek abortions, to begin with, and the few that I have referred, yes, they had very significant stress, emotional trauma, horrible home situations. But I refer very, very few women for abortions." Tr. 379:4-9. On the rare occasions she does counsel women regarding abortion, the extensive care and attention she gives women bears little resemblance to the 2 to 10-minute session they receive at Planned Parenthood:

> Q: But you've counseled patients about whether to keep or terminate their pregnancies. Is that fair?
> A: I counsel patients when they come to me and – and ask me if it would be possible to have an abortion.
> Q: So what do you say when a woman comes to you and says, will it be possible for me to have an abortion?
> A: We – I do – as I do with all my patients, I go through a medical history and talk to her about the situation and try and look at her in the whole – whole nature of her life and her problems, and we determine together if she feels like this is definitely, albeit a terrible option, the best option for the health and – health of herself and her family, then I will give her the phone number to an abortion provider.

Tr. 375:4-376:9. Dr. Smith's practice more closely resembles Dr. Lantzman's private practice at Alaska Native Health Center, which does not provide abortions, than his contract practice providing abortions at Planned Parenthood. At the health center, his

counseling sessions are much longer—forty-five minutes rather than two to ten minutes—and involve "congratulations," counsel about conditions to be aware of and warnings about pregnancy risks, such as alcohol and drug abuse. Tr. 429:6-18.

The overwhelming weight of medical testimony at trial also established that the State's interpretation of SB 49 to require a need to avoid a "serious risk" to the patient's health reflects the general standard of practice for medical necessity for abortion. Dr. Steve Calvin, an experienced obstetrician-gynecologist and maternal-fetal specialist who has performed what he regards as "medically necessary" abortions (Tr. 646:1-14) and who advises a woman to consider termination if pregnancy is going to cause a serious deterioration in her medical condition (Tr. 653:21-25), testified that S.B. 49 "covers all the possible scenarios" in which physical conditions make an abortion necessary to protect a pregnant woman's health. Tr. 647:2-10. Dr Calvin based his opinion on the "fairly comprehensive list of a number of fairly severe medical complications of pregnancy" provided by the statute, and also the "discretionary clause" in the final clause "that allows a physician to make the determination that a – that a pregnancy is life threatening." Tr. 647:12-14.

S.B. 49, codified at Alaska Statute 47.07.068(b), defines "serious risk to the life or physical health" of the patient in non-exclusive terms to include "a serious risk" of death or "impairment of a major bodily function because of" twenty-two enumerated conditions and an open-ended "catch-all" for "another physical disorder, physical injury, or physical illness" that poses similar risks. Testimony at trial established that

the enumerated conditions either represent serious pregnancy complications or conditions in pregnancy that may progress to serious complications.

For cervical or cesarean section scar ectopic implantation (xix) and other non-uterine pregnancies (xx), termination is the standard treatment. Other conditions common to pregnancy include diabetes that is controlled during the pregnancy, which generally doesn't harm the patient and "is . . . fairly well controlled by available medical means that are not extraordinary." Tr. 661:17-662:19 (Calvin). Even in cases of diabetic ketoacidosis, "abortion wouldn't be the first treatment modality" because "the process of the abortion itself is an additional stress and there are other treatment options." Tr. 663:2-7 (Calvin). However, renal abnormalities with obesity, making a patient highly susceptible to kidney infections, could be a reason for termination in a physician's discretion, according to the State's expert Dr. Calvin. Tr. 658:3-9. Obesity alone does not make an abortion medically necessary—one-third of all U.S. women have a body mass index between twenty-five and thirty, indicating obesity (Tr. 656:4-5), though according to Dr. Calvin, it could factor into a recommendation. Tr. 656:11-25.

Gestational diabetes only affects 5 to 10 percent of pregnancies, pregestational diabetes about 1 to 2 percent of pregnancies. Tr. 28:19:22-24 (Caughey). Severe conditions related to diabetes—diabetic ketoacidosis—only occurs in Type 1 diabetics, about 5 percent of pregestational diabetics. Tr. 101:2-21 (Caughey). A woman with diabetes can have a successful pregnancy, as Planned Parenthood's expert Dr. Caughey admitted. Tr. 99:10-25. Likewise, a patient with an autoimmune disease, or

hypertension, can as well. Tr. 99:22-25. In fact, Dr. Caughey agreed, there are not very many preexisting health conditions that would lead him to recommend that a woman terminate a wanted pregnancy. Tr. 99:22-25.

Where a patient is experiencing convulsions (v), seizures (xiv), status epilepticus[25] (vi), or epilepsy (xiii), Dr. Caughey testified without contradiction that terminating the pregnancy usually is not going to alleviate the seizures, except in cases of eclampsia. Tr. 55:5-11. Sickle cell anemia (v), a condition that debilitates the blood's ability to carry oxygen, can lead to situations that Dr. Caughey called "pain crises". Tr. 57:8-58:16. Because a patient with this condition experiences accelerated serious conditions, the Court in *State, DHSS* noted that it is regarded as giving rise to a "necessary" termination. *State, DHSS,* 28 P.3d 907.

Pulmonary hypertension (ix) is a serious and rare condition that is to be distinguished from pregnancy-induced hypertension. Chronic hypertension affects only about 5 to 10 percent of all pregnancies. Tr. 28:19:20-22 (Caughey). Malignancies preventing or limiting treatment (x) are "challenging," according to Dr. Caughey, Tr. 87:24-882, but only "a few" cancers are hastened by pregnancy, and many actually are not necessarily affected by it. What is affected is the ability to treat the cancer; but for almost every health condition, Dr. Caughey testified, it is "a handful of drugs" that is not used because of the risk to the embryo or fetus. Tr. 63:12-23 (Caughey).

Kidney infection (xi) and "severe infection exacerbated by pregnancy" (xvi) only rarely result in serious complications. Kidney infection is common in pregnancy;

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[25] Status epilepticus is a state of continuous or extended seizure activity. Taber's Medical Cyclopedia 2066 (20th ed.).

perhaps 1 to 2 percent of patients will develop one, according to plaintiff's expert Dr. Caughey. Tr. 64:11-13. Bladder infections are a little more common, at about 5 to 10 percent. Tr. 64:13-14. "But having the risk of death or impairment of a major bodily function [from these conditions] would be incredibly rare." Tr. 64:9-15 (Caughey).

Numerous conditions that plaintiff's experts regarded as giving rise to medically necessary terminations do not typically arise or are not observable until after viability, when delivery by induction into the care of a neonatal intensive care unit (NICU) (obviously payable by Medicaid) is the standard treatment, not abortion. Macrosomia, for example, is not known until well beyond viability. Tr. 656:9-19 (Calvin). Preeclampsia (iii) and (iv) ordinarily do not occur before twenty weeks' gestation, and even at twenty-four weeks is "pretty rare," according to Planned Parenthood's Dr. Lantzman. Tr. 440:17-19. Premature rupture of amniotic membranes (xvii) occurring before thirty-seven weeks but before viability is a preterm event. When it occurs prior to about twenty-three or twenty-four weeks, it is considered a pre-viable, premature rupture, which engenders a high risk of infection with a low chance of a good outcome for the fetus. Tr. 66:23-67:7. Rupture before viability, however, is "pretty rare," according to Dr. Caughey, and involves only about one to two patients a year in his practice. Tr. 67:16-25. Where "advanced cervical dilation of more than six centimeters at less than 22 weeks gestation" (xviii) is observed, delivery by induction is indicated. Tr. 68:17-18 (Caughey: "I've never seen someone 6 centimeters dilated at 22 weeks that wasn't about to deliver."). Amniotic fluid embolus (xxi) is a rare condition that also only occurs during labor. Tr. 71:5-15 (Caughey).

Finally, Planned Parenthood makes much of the statute's failure to provide for funding for abortions based upon non-somatic conditions. But the evidence at trial put the lie to Planned Parenthood's position that the two-thirds of its Medicaid-funded abortions for claimed psychiatric or emotional conditions were truly medically necessary, or even that they were found to be indicated pursuant to a recognized standard of practice. Planned Parenthood's Dr. Lantzman confirmed that in spite of preexisting psychological conditions, a patient can still have a successful pregnancy. Tr. 412:1-3. The incidence of depression in pregnancy is not higher than at other times, but it is slightly elevated afterward. Tr. 297:17-298:7 (Metzer-Brody). Nor does exposure to teratogenic medications alone make an abortion medically necessary, Dr. Metzer-Brody confirmed. Tr. 295:9-11.[26] Mental illness can be treated with medication during pregnancy, according to Metzer-Brody. Tr. 266:20-267:8. Metzer-Brody does not believe a pregnant woman should stop her medication altogether once she becomes pregnant, calling this a "misguided approach to treatment of pregnant women based on lack of experience." Telling patients to stop their psychiatric medications "can put people at extreme risk," she stated. Tr. 267:6-8.

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[26] The two most commonly cited medications are Lithium, used to treat bipolar disorder, and Valproate (Depakote), an anti-convulsant which is also FDA-indicated for bipolar disorder. Tr. 268:4-22 (Metzer-Brody). Lithium has been thought as increasing the risk of Ebstein's anomaly, a cardiac defect, although according to Dr. Metzer-Brody, "more recent reports have downgraded the extent of that." Tr. 268:8-9. The absolute risk of Ebstein's anomaly is less than one percent. Tr. 294:14-16. Valproate has been associated with an increased risk of neural tube defects such as spina bifida. Tr. 294:19-20. Dr. Metzer-Brody stated that there are alternative medications available, although for some women only these medications control their symptoms. Tr. 294:11-295:24.

Dr. Metzer-Brody admitted that no study on perinatal mental illness explicitly identifies abortion as a treatment for the illness (Tr. 280:23-281:1):

> Q: And in your published work, you've never mentioned abortion as a treatment for any mental disorder, have you?
> A: I have not.
> Q: Okay. And none of the studies that you cite in your expert report discuss abortion as a potential treatment for a mental disorder?
> A: I don't think abortion is ever discussed as a treatment in the same way we consider medication treatment or psychotherapies. So it is, for better or for worse, in its own special unique category, so it doesn't fall under a rubric of treatment, per se, and I think that's because the medical profession sees ending a pregnancy as a very serious decision, but I don't think it's bandied about as considered treatment, and – and as such has not been studied nor published.

Tr. 301:17-302:6 (Metzer-Brody). Dr. Bibault likewise confirmed that none of the articles cited in her report mention abortion as a treatment for mental health conditions in pregnancy. Tr. 243:14-19. In fact, Dr. Bibault testified, there are no studies showing that once neurohormonal changes by pregnancy are set in motion, that abortion reduces the likelihood of suffering depression after the pregnancy has ended. Tr. 301:2-6.

According to psychiatrist Dr. Renee Bibault, psychiatry "is a very, very complicated field of study and the treatment decisions are very complex and nuanced. . . . It requires a lot of collaboration with patients, a lot of education, and very individualized treatment approaches." Tr. 190:114-19. Diagnostic standards in the DSM-5 state that psychiatric patient care requires clinical training to recognize when the combination of predisposing, precipitating, perpetuating, and protective factors have resulted in a clinically diagnosable condition. Tr. 231:24-232:8 (Bibault). Bibault testified that, to assess an impairment in function, requires "a careful history" of the patient, Tr. 232:21-233:6, which for a first-time patient entails having a "long interview,

basically, where we ask about current symptoms. I ask about any previous psychiatric diagnosis. I take a careful social and developmental history and educational history, relationship history, find out what illnesses her family members have had, do a mental status examination, which is the equivalent of a physical examination but for psychiatry." Tr. 233:13-22. This process of evaluation takes "[b]etween 60 and 75 minutes," according to Dr. Bibault. Tr. 234:9-12.

Plaintiff's experts Dr. Metzer-Brody and Dr. Smith similarly testified to the intensive interview the standard of practice requires to develop a psychiatric treatment plan:

> As a board-certified psychiatrist, there is an agreed upon way of doing a new patient evaluation, so you would – as the earlier witness, I would concur completely, that we do a comprehensive psychiatric evaluation that includes but [is] not completely limited to the person's chief complaint, presenting complaint, her current psychiatric symptoms, her past psychiatric history, including past treatment, her past medical history, her past surgical history, her family history, her psychosocial stressors, her psychosocial developmental history, a current psychiatric mental status exam, and then an assessment and sort of a formulation or summary that takes into account both biological, psychological and social contributions to her presentation at that time. And then we develop a treatment plan.

Tr. 258:8-259:3 (Metzer-Brody). *See also* Tr. 325:25-327:11 (Dr. Smith describing extensive medical history taken of patients); Tr. 287:24-288:17 (Dr. Metzer-Brody describing comprehensive psychiatric interview with first-time patients). This extensive process of evaluation bears no resemblance to the truncated two-to-ten-minute visit a woman receives at Planned Parenthood, which essentially rubber-stamps her decision to terminate the pregnancy.

CONCLUSION

For the reasons set forth above, Amicus Curiae urges this court to uphold S.B. 49 as a reasonable and constitutional expression of "medical necessity" for abortion that reflects the standard of practice. This Court should keep its word to the people of Alaska, given in *State, DHSS*, that the State is not required to fund "elective abortions." If this Court rules at this time that all abortions are "medically necessary" simply because they are desired by a woman for any reason whatsoever, then this Court would be marking its decision in *State, DHSS* as a mere exercise in sophistry. This Court's decision in *State, DHSS* commands that there be a distinction between "medically necessary" abortions and "elective abortions." This Court should prove its prior distinction true, and uphold S.B. 49 as a reasonable delineation based upon medical science, knowledge, and practice.

DATED this 15th day of April, 2016

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APPENDIX A

APPENDIX A

Q Now, in your practice the State will pay for a minor girl's abortion -- and again we're -- I'm speaking now at this time of -- when I speak of a minor I'm talking about the classification of 16 and under for our purposes of definitions -- and the State will pay for any abortion that is medically necessary; is that correct?

A Correct.

Q And since you've been practicing since 1985 you have been able to find a medical necessity for State-paid abortions for these girls except perhaps for only 10; is that correct?

A I believe that's what I said in my deposition.

Q And your definition of medical necessity is what you refer

to if the pregnancy is an affront to the minor; is that correct?

A It's that the pregnancy in some way is a threat to the patient's medical or psychological well-being.

Q And what you use for a definition is a theoretical hazard to her mental health; is that correct?

A I think I've used those terms.

Q And this could mean that if, in fact, the pregnancy would cause her some conc-- problems in dealing with education, her continued employment, things of this nature, would be

the kind of affront you're talking about; is that correct?

A Independence would be another one, the ability to raise a family. There's multiple factors that will go into it.