JURISDICTIONAL STATEMENT

The superior court issued a decision on August 27, 2015 and entered judgment on October 7, 2015. [Exc. 166-67; R. 499] This Court has jurisdiction under AS 22.05.010.

PARTIES

Appellants are the State of Alaska and the Commissioner of the Department of Health and Social Services. The appellee is Planned Parenthood of the Great Northwest.

STATEMENT OF THE ISSUES

I. Statutory interpretation. The Alaska Constitution requires Medicaid funding for abortions when pregnancy threatens a woman's health. The Legislature enacted a law providing funding when abortion will "avoid a threat of serious risk to the life or physical health of a woman." Although the law provides funding for "a *threat* of serious risk" to *health*, the superior court interpreted it to cover only abortions needed to save a woman's life, making the law unconstitutional. Should the court have interpreted the statute instead to include funding for abortions when pregnancy threatens a woman's health?

II. Equal protection. The Court has ruled that limiting Medicaid funding for abortion to life-threatening pregnancies violates equal protection, because in other contexts Medicaid funds all medically necessary care. Although the superior court interpreted a recently enacted law to fund only abortions necessary to save a woman's life, the law's text and legislative history indicate that it also covers abortions needed to protect a woman's health. Does the new law violate equal protection?

III. Constitutional definition of "medically necessary." The Court has held that Medicaid must cover "medically necessary" abortions but stated that its holding does "not

concern State payment for elective abortions." After a trial showing that abortion providers find every abortion to be medically necessary—even if the reason is purely socio-economic—the superior court held that the Constitution requires the State to allow physicians unfettered discretion to decide when an abortion is medically necessary for purposes of Medicaid funding. Does the Alaska Constitution require state funding of all abortions for Medicaid-eligible women?

INTRODUCTION

This appeal presents the question of whether the State of Alaska's Medicaid program can effectively distinguish between abortions that are needed to protect a pregnant woman's health and elective abortions that Medicaid need not pay for. In *State, Department of Health and Social Services v. Planned Parenthood of Alaska, Inc. ("Planned Parenthood 2001")*, this Court held that Medicaid must pay for an abortion if it is needed to protect a woman's health.[1] The Court acknowledged the distinction between medically necessary abortions and elective abortions but did not explain how to draw the line between the two.[2]

The statute at issue in this appeal, AS 47.07.068, draws that line by providing that an abortion is medically necessary if, in the physician's professional judgment, continuing the pregnancy poses a "threat of a serious risk to the life or health of the pregnant

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1 28 P.3d 904, 905-06 (Alaska 2001).

2 *Id.* at 905. ("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.").

woman."[3] The statute contains a non-exclusive list of health conditions illustrating the type of conditions that represent "serious risk to the life or health of the pregnant women," so that if the physician reasonably believes that continuing the pregnancy poses a "threat" of developing these or similar conditions, Medicaid will pay for an abortion.[4] In practice this means that Medicaid will cover an abortion for women who have any of a wide range of conditions that commonly complicate pregnancy, such as obesity, diabetes, and preeclampsia. Alaska Statutes 47.07.068 thus adopts for abortion the same principle applicable to funding throughout the Medicaid program—Medicaid will pay only for procedures that are "medically necessary"[5] and will not pay for any procedure that is not "reasonably necessary for the diagnosis and treatment of an illness or injury, or for the correction of an organic system."[6] In doing so, AS 47.07.068 resembles other Medicaid provisions that define a standard of medical necessity in the context of particular services or procedures that patients may desire even if not needed to protect their health.[7]

The superior court's conclusion that AS 47.07.068 violates Alaska's equal protection clause[8] rests on a profound misreading of the statute. The superior court interpreted it to cover abortion in an extremely narrow set of circumstances: only if a

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3 AS 47.07.068(b).

4 AS 47.068(b)(3)–(4).

5 7 AAC 105.100(5).

6 7 AAC 105.110(1).

7 *E.g.*, 7 AAC 135.020(a) (necessity criteria for behavioral health services); 7 AAC 105.110(4) (necessity criteria for reconstructive surgery); 7 AAC 110.153 (necessity criteria for orthodontia).

8 Alaska Const. Art. I, § 1.

serious health condition is "either fully realized or demonstrably imminent." [Exc. 109] Yet the superior court arrived at that conclusion by ignoring basic canons of statutory construction. It revised the operative text to render it meaningless.[9] It gave more weight to selective snippets of legislative history than to the legislative history overall or to the statutory text itself. [Exc. 108] And although the superior court conceded that the statute is "susceptible" to an interpretation that authorizes broad Medicaid coverage for abortions, it decided to interpret the statute narrowly instead—despite its duty to interpret the statute in a constitutional way whenever possible.[10] [Exc. 106] These errors fatally infect the superior court's equal protection analysis.

The superior court also mistakenly believed that this Court's 2001 decision precludes the State from drawing *any* line to effectively distinguish between elective abortions and abortions needed to protect a woman's health. While acknowledging that this Court expressly distinguished between elective and medically necessary abortions and limited its ruling on Medicaid's constitutional obligations to the latter,[11] the superior court concluded these statements were essentially meaningless. [Exc. 126] The court should not have discounted the distinction that this Court so carefully preserved.

Finally, the superior court failed to recognize that in this facial challenge,

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9 "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 . . . .'" [Exc. 109 (brackets in original)].

10 *State, Dept. of Revenue v. Andrade*, 23 P.3d 58, 71 (Alaska 2001) (recognizing "the well-established rule of statutory construction that courts should if possible construe statutes so as to avoid the danger of unconstitutionality" (quoting *Kimoktoak v. State*, 584 P.2d 25, 31 (Alaska 1978)).

11 *Planned Parenthood 2001*, 28 P.3d at 905.

AS 47.07.068 must be upheld if "despite any occasional problems it might create in its application to specific cases, [it] has a plainly legitimate sweep."[12] The court focused on rare but difficult situations—like a twelve-year old girl impregnated by a peer—then dismissed the idea that Medicaid's obligation to fund an abortion in that circumstance could be raised in an as-applied challenge. [Exc. 113] In fact, Medicaid is tailor-made for as-applied challenges because the program reimburses physicians for care already provided. If reimbursement is denied, Planned Parenthood can appeal the denial to an administrative tribunal and the courts.[13] The only consequence of an unsuccessful challenge is that the provider will not be paid for the procedure. The outcome will have no bearing on the woman who received the abortion. For this reason, the statute should be upheld so long as it fairly traces the line between elective and medically necessary abortions, "despite any occasional problems" in its application to rare situations.

STATEMENT OF THE CASE

I. Statement of the Facts

A. Alaska's Medicaid Program

Medicaid is a cooperative federal-state insurance program that covers healthcare for poor Alaskans.[14] The State of Alaska participates in the Medicaid program through the Department of Health and Social Services (DHSS).[15] Under the Medicaid Act, the

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12 *State v. Planned Parenthood of Alaska*, 171 P.3d 577, 581 (Alaska 2007).

13 7 AAC 105.270(a); 7 AAC 105.280(a), (e).

14 *Alaska Dep't of Health and Soc. Servs. v. Ctr. for Medicare and Medicaid Servs.*, 424 F.3d 931, 934-35 (9th Cir. 2005); *accord* 42 U.S.C § 1396.

15 AS 47.07.010.

federal government underwrites part of the costs of state Medicaid programs.[16] In order to receive this federal funding, the State must comply with the requirements of the federal Medicaid Act and with federal regulations.[17] Within the framework established by federal law, Alaska statutes and regulations shape the contours of Alaska's Medicaid program: who is eligible,[18] what services are covered and when,[19] and the conditions with which medical providers must comply to receive payment.[20]

Medicaid does not reimburse every medical service that a patient might want, nor every service that a doctor might think will improve a patient's well-being. Alaska's Medicaid program will pay for a medical procedure or service only if it is "medically necessary as determined by criteria established under [Alaska's Medicaid regulations] or by the standards of practice applicable to the provider."[21] It will not cover a service or procedure if it is "not reasonably necessary for the diagnosis and treatment of an illness or

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16 *See San Lazaro Ass'n, Inc. v. Connell*, 286 F.3d 1088, 1092 (9th Cir. 2002).

17 *San Lazaro Ass'n, Inc.*, 286 F.3d.at 1092.

18 AS 47.07.020; 7 AAC 100.001-.990.

19 AS 47.07.030 ("Medical services to be provided"); AS 47.07.032 ("Inpatient psychiatric services"); AS 47.07.045 ("Home and community-based services"); AS 47.07.046 ("Traumatic or acquired brain injury services"); AS 47.07.065 ("Payment for prescribed drugs"); AS 47.07.067 ("Payment for adult dental services"); *see generally* 7 AAC 105.100-105.130; 7 AAC 110.100 – 140.720.

20 *E.g.* AS 47.07.070 ("Payment rates for health facilities"); AS 47.07.074 ("Audits and inspections"); AS 47.07.075 ("Administrative procedure"); *see generally* 7 AAC 105.200-.490; 7 AAC 140.100-150.990.

21 7 AAC 105.100(5).

injury, or correction of an organic system, as determined upon review of the department."[22]

The Medicaid program enforces these baseline criteria using various standards and procedures. For all services and procedures billed, DHSS may conduct post-payment audits of medical providers to determine compliance with the statutory and regulatory requirements of the Medicaid program,[23] and it has a range of tools to ensure compliance with the medical necessity requirement.[24] Certain services are subject to additional standards or procedures to ensure that Medicaid is billed only for medically necessary care, such as standardized tools for assessing eligibility,[25] a requirement that a provider seek pre-authorization for coverage,[26] or specialized standards of medical necessity.[27]

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22 7 AAC 105.110(1). The "medical necessity" requirement is a reasonable interpretation of the overall statutory purpose of the Medicaid program, which is to provide "needy persons ... who are eligible for medical care at public expense" "only uniform and high quality care that is appropriate to their condition and cost-effective to the state...." AS 47.07.010.

23 7 AAC 160.110(a).

24 7 AAC 105.260(a)(8), (b) (authority to recoup Medicaid payments); 7 AAC 105.470 (authority to require provider to seek prior authorization for services).

25 Coverage is offered for personal care assistants only if applicant attains a certain score on DHSS assessment tool. 7 AAC 125.010(a); 7 AAC 125.020(a)-(c). Coverage is offered for home and community-based services is offered only if applicant satisfies a DHSS assessment of the applicant's physical, emotional, and cognitive functioning. 7 AAC 130.205(d); 7 AAC 130.213(a)-(b).

26 7 AAC 105.130. DHSS reviews prior authorization requests for "medical necessity, clinical effectiveness, cost-effectiveness, and likelihood of adverse effects," as well as service-specific requirements detailed in regulation. 7 AAC 105.130(c).

27 *E.g.*, 7 AAC 105.110(4) (cosmetic or reconstructive surgery); 7 AAC 110.153 (orthodontia); 7 AAC 135.020(a) (behavioral health clinic services; 7 AAC 135.020(b) (behavioral health rehabilitation services).

B. The 2001 *Planned Parenthood* decision

In *Planned Parenthood 2001*, this Court ruled that the State must provide Medicaid funding for medically necessary abortions.[28] The Court did not define the term "medically necessary."[29]

Planned Parenthood 2001 addressed a challenge to a state regulation that limited Medicaid funding for abortions. The regulation mirrored federal criteria for funding of abortions—the so-called "Hyde Amendment"—which provide that federal funds may not be used to pay for an abortion unless the pregnancy threatens the woman's life or is the result of rape or incest.[30] Superior Court Judge Sen Tan held that the State's identical regulation violated the Alaska Constitution's right to privacy.[31] On appeal, this Court affirmed on a different basis, ruling that the regulation violated Alaska's equal protection clause because it denied funding for medically necessary abortions even as Medicaid covered virtually all other medically necessary care for low-income Alaskans.[32] But the Court limited its holding to the requirement that the State fund medically necessary abortions, stating that the case did "not concern State payment for elective abortions."[33]

After this Court's decision, the State adopted the definition for "medically necessary" abortions that Judge Tan had incorporated into the superior court injunction.

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28 28 P.3d 904.
29 *Id.* at 907.
30 *Id.* n.8.
31 *Id.* at 907.
32 *Id.* at 913.
33 *Id.* at 905.

[Exc. 81-82] Judge Tan defined "medically necessary" abortions as "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." [Exc. 10] This was "determined by the treating physician performing the abortion services in his or her professional judgment." [Exc. 10]

Despite the Supreme Court's caveat that *Planned Parenthood 2001* did not require Medicaid to pay for elective abortions, in practice this judicially imposed standard has resulted in Medicaid covering abortions for all unwanted pregnancies. For example, in 2014 Medicaid was billed for every Alaska Medicaid-eligible woman who received an abortion at Planned Parenthood. [Tr. 150]

C. New regulation and statute defining medically necessary abortions

Eventually, state officials recognized this development and attempted to create a standard that would effectively distinguish between elective and medically necessary abortions.[34] In 2013, DHSS adopted a regulation defining when an abortion is "medically necessary" for purposes of Medicaid coverage. [Exc. 35-39] In 2014, the Alaska Legislature passed a law creating a slightly different definition of medical necessity.[35] The resulting statute, AS 47.07.068, provides that Medicaid will not pay for abortion services unless they are for a medically necessary abortion or the pregnancy is the result

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34 Minutes of the Senate Finance Comm., 28th Leg., March 29, 2013, at 4-5, found at http://www.akleg.gov/pdf/28/M/SFIN2013-03-290908.PDF (last visited April 12, 2016).

35 AS 47.07.068.

of rape or incest.[36] The statute defines when an abortion is medically necessary:

> "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 . . . .[37]

The statute further defines "serious risk to the life or physical health" to include, but not be limited to, "a serious risk to the pregnant woman of (A) death; or (B) impairment of a major bodily function because of" a list of twenty-one enumerated medical conditions and a catch-all provision:

> 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.[38]

II. Statement of the Proceedings

A. Pre-trial proceedings

Shortly before DHSS's regulation became effective, Planned Parenthood filed suit and sought a temporary restraining order. [Exc. 11; R. 149] The superior court granted the TRO, subsequently converting it into a preliminary injunction. [R. 109] After

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36 The provision for pregnancies resulting from rape or incest mirrors the federal Hyde Amendment. *See* 42 C.F.R. § 441.203. Because DHSS may not use any federal Medicaid funds to pay for an abortion unless it meets federal criteria, payments for an abortion cannot be processed in the same way as the majority of procedures and services that are eligible for matching federal funds. [Tr. 591] To ensure that the correct billing procedure is followed and the correct funding source is used, DHSS needs some way to determine whether an abortion meets federal criteria. Since 2012, DHSS has employed a certification form for this purpose. [Tr. 591]

37 AS 47.07.068(b)(3).

38 AS 47.07.068(b)(3).

AS 47.07.068 was enacted, Planned Parenthood amended its complaint and asked the superior court to enjoin this statute. The court granted a preliminary injunction pending the scheduled trial and the court's ruling on a permanent injunction. [R. 305-307] Planned Parenthood also moved for summary judgment solely on the regulation on the theory that it had been repealed by the subsequent statute, and the court denied the motion. [R. 976]

B. Trial

The superior court held a seven-day evidentiary hearing. [Tr. 1-903] Testifying on behalf of Planned Parenthood were: obstetrician/gynecologists Aaron Caughey, Jan Whitefield, and Eric Lantzman; psychiatrists Renee Bibeault and Samantha Meltzer-Brody; and family medicine physician Sharon Smith. Testifying on behalf of the State were: DHSS's deputy commissioner for Medicaid Jonathan Sherwood; DHSS health program manager Cindy Christensen; obstetrician/gynecologists Steve Calvin and Jean Bramer; and psychiatrist Eileen Ryan. The evidence, primarily witness testimony, focused on the risks posed by pregnancy, when abortion may be medically necessary, and whether the challenge statute covered these conditions.

1. Testimony about the risks of pregnancy

Both parties' witnesses agreed that pregnancy can negatively impact a woman's health, either by aggravating existing conditions or by inducing new ones.

They agreed that obesity can cause complications in pregnancies. Dr. Calvin testified that obesity places more stress on a woman's system, increasing the risk of gestational diabetes. [Tr. 654] Pregnancy in obese women also increases the cardiac

burden, the rate of caesarian sections, and the risk of infection, macrosomia, and preeclampsia. [Tr. 443, 655-59]

Diabetes is a risk factor also identified by several witnesses. Pregnancy can make diabetes more difficult to control. [Tr. 44] If a pregnant woman is not able to control her diabetes, it can result in life-threatening complications. [Tr. 662] Out-of-control diabetes increases the incidence of fetal macrosomia, post-partum hemorrhage, infections, blood clots, and pulmonary embolus. [Tr. 33, 483] A woman with gestational diabetes during pregnancy has a higher risk of developing it in a subsequent pregnancy. [Tr. 701-02]

The witnesses also agreed that hypertension can make pregnancy more risky. Dr. Caughey testified that women with chronic hypertension have high rates of preterm birth, preeclampsia, and growth-restricted fetuses. [Tr. 31] Dr. Calvin cited the same conditions and testified that pulmonary hypertension is particularly dangerous, with a high risk of death. [Tr. 652, 667]

Both parties' witnesses discussed the risk of preeclampsia, which Dr. Calvin described as "a maternal reaction to the placental tissue." [Tr. 670] If severe, preeclampsia can be life threatening; it can cause women to have seizures, strokes, rupture of the liver capsule, and severe hematologic abnormalities. [Tr. 670] Dr. Caughey cited the same risks, adding damage to the kidneys and lungs. [Tr. 51] Preeclampsia typically occurs after viability, so in severe cases treatment is usually early delivery. [Tr. 52-53, 670-71, 703] Preeclampsia has a recurrence rate in subsequent pregnancies of 15-50 percent. [Tr. 53-54]

Pregnancy also can aggravate heart conditions or heart disease, the witnesses agreed. In a typical pregnancy, a woman's blood flow increases by 50 percent, making the heart work harder. [Tr. 60] A woman with an asymptomatic heart condition can discover it during pregnancy because of the additional blood flow. [Tr. 61] Pregnancy can significantly worsen any heart condition. [Tr. 650] Heart disease is described by four classes that range from mild to severe, and pregnancy can move a patient from one classification to higher ones, sometimes permanently. [Tr. 704-705]

The only main area of disagreement between the witnesses was in the relationship between pregnancy and mental health. Witnesses for both parties acknowledged that pregnancy can trigger or exacerbate mental illness, although why it does so is not well understood. [Tr. 200, 205, 261, 794-95] They disagreed, however, about whether abortion is an effective treatment for pregnancy-related mental illness. Dr. Ryan testified that abortion is never an indicated treatment for mental illness and noted that neither published studies nor the statements of professional organizations show that it is an effective treatment for pregnancy-related mental illness. [Tr. 790, 804] Although Planned Parenthood's witnesses did consider abortion to be a valid treatment for mental health conditions, they acknowledged that no studies or literature supports that view.
Dr. Bibeault testified that she did not know of any articles that mention abortion as a treatment for mental health conditions in pregnancy, which she attributed to the difficulty of conducting these studies and to research lagging clinical practice. [Tr. 221, 243-244] Dr. Meltzer-Brody also was unaware of any studies on perinatal mental illness that identify abortion as a treatment for mental illness. [Tr. 280-81] Yet both Drs. Bibeault

and Meltzer-Brody believe that abortion can treat pregnancy-related mental illness, based on experience from their practices. [Tr. 210, 262]

2. Testimony about when abortion is medically necessary

Planned Parenthood's medical witnesses generally did not testify about when an abortion might be medically necessary—a term described by Dr. Caughey as an insurance concept [Tr. 34]—but instead testified about when an abortion might be medically indicated. In their view, the concept of medically indicated is essentially anything that could improve the patient's wellbeing. Dr. Caughey, for example, defines "medically indicated" as treatments for which "the outcomes with that treatment would be better than if the treatment were not done." [Tr. 34] Dr. Whitefield defines "medically indicated" as a term that applies to a procedure or a medication that will help "a patient [who] has a problem and a medication or procedure can help that problem." [Tr. 472] Dr. Smith was willing to use the term "medically necessary treatment," defining it as a "treatment that ensures the health and well-being of a patient." [Tr. 368]

With this frame of reference, Planned Parenthood's medical witnesses expressed the view that abortion can be medically indicated for many reasons that are more commonly thought of as personal circumstances than as medical conditions. Dr. Caughey testified, for example, that because carrying a pregnancy to term is associated with greater risk than having an abortion, all abortions could be medically indicated, depending on each patient's willingness to assume risk. [Tr. 109] Dr. Smith expressed a similar view, agreeing that abortion is medically necessary for some women because their pregnancies create stress and anxiety that could threaten their health. [Tr. 378-79] And Dr. Bibeault

found abortion to be medically appropriate whenever "it seemed like ending the pregnancy state would improve" a "great deal of distress and suffering." [Tr. 211] She defined distress as "negative emotions such as fear or anguish or sadness or difficulty coping." [Tr. 230]

Under this approach, any circumstances in which an unwanted pregnancy would create stress makes an abortion medically indicated. Dr. Smith noted that the need to forgo educational opportunities can cause stress. "Women . . . who have aspirations and hopes of going and following their dreams and getting an education who are suddenly not able to do so are at risk of psychological disease, be that anxiety, depression, lack of sleep." [Tr. 362] Dr. Smith also finds an abortion to be medically necessary when a pregnancy will negatively affect a woman's socioeconomic status in a way that is "not in the interest of [her] health." [Tr. 336-37] In her view, medically relevant factors include a woman's housing situation, current family size, career goals, and educational status. [Tr. 80-82, 106] In addition, an abortion could be medically necessary for a woman who is poor, a woman who does not have the capacity to deal with a child with disabilities, a woman with a substance abuse problem, or a woman with an abusive partner. [Tr. 222, 276, 358, 360, 415, 419, 487, 489, 491-92, 490, 487] Any unwanted pregnancy could have a similar negative impact on a woman's health: "[T]here are huge consequences for her health because then she is being forced . . . to enter a part of her life that was not how she planned it, and it leads to anxiety, depression." [Tr. 364]

Dr. Lantzman, who provides abortions at Planned Parenthood, finds that health and well-being are interrelated and therefore does not have "hard and fast criteria" for

determining when an abortion is medically indicated. [Tr. 406] He testified that he determines whether an abortion is medically necessary by communicating with a patient: "[W]hen I meet a patient, I walk into a room, I introduce myself as the physician, who I am, and then I let them know that the State of Alaska requires that there's a medical, emotional or psychological reason that they're having this procedure done today to pay for the procedure and does one of those things apply for that individual[?]" [Tr. 406] Dr. Lantzman spends between two and ten minutes, on average, talking to a woman to determine whether her abortion is medically necessary. [Tr. 422]

The malleability of Planned Parenthood's concept of medically indicated means that in practice an abortion is medically indicated any time a patient desires one. Dr. Lantzman, along with Planned Parenthood's other doctors, does not find abortion to be anything other than medically necessary when a woman wants to terminate a pregnancy. [Tr. 422] Dr. Whitefield did not dispute Planned Parenthood's statement—made in response to an interrogatory— that its current physicians were "unable to recall patients for whom they determined abortion was not medically necessary after reviewing the patient's medical history, age, prior pregnancies, overall health and risk factors and discussing with the patient her reason for having an abortion." [Tr. 462] Drs. Whitefield and Lantzman both testified that they had never found an abortion not to be medically necessary. [Tr. 422, 460, 481, 522] Dr. Whitefield did not find this surprising, because the women who see him at Planned Parenthood "have come there because they're not particularly happy about their pregnancy . . . and they would like to be able to try to do something about it." [Tr. 505] Planned Parenthood's other medical witnesses have the

same view. Dr. Caughey had never seen a woman seek an abortion that he would characterize as elective. [Tr. 123] And Dr. Smith agreed with Judge Suddock's observation that doctors at the clinic are "always going to check that [medically necessary] box, aren't they, as a practical matter?" [Tr. 383]

C. Decision

The superior court ruled that AS 47.07.068 and 7 AAC 160.900(d)(30) violate the Alaska Constitution's equal protection clause and enjoined their enforcement. [Exc. 130]

The court recognized that Planned Parenthood and the State "interpret the statute very differently." [Exc. 106] The State read the law to authorize "a physician to perform abortions and thus avoid non-trivial physical health detriments that the physician can concretely name." [Exc. 106] Planned Parenthood, on the other hand, read it "as the Hyde Amendment in disguise, effectively a life endangerment standard." [Exc. 106] But while the court found the statute to be "susceptible to both interpretations," the statute's legislative history convinced the court that the Legislature intended the law to be "a high-risk, high-hazard standard that would preclude funding for most Medicaid abortions." [Exc. 106] The court based this conclusion on the statement of Dr. John Thorpe, a witness at a legislative hearing who testified that the bill's list of conditions include those that would cause a doctor to "advise a pro-life patient who desired to carry to term to have an abortion for her own safety." [Exc. 108-09]

In light of its reading of the legislative history, the superior court changed the statute's wording accordingly: "the statute addresses 'a threat [consisting] of a serious risk to the physical health of the woman,' and not merely possible remote risks."

[Exc. 109] Having made this change, the court rejected the State's argument: the statute does not require women to be suffering from the listed conditions, but requires only that the physician reasonably conclude that continuing the pregnancy poses a threat of developing those or similar conditions. [Exc. 109] Instead, the court concluded, the statute "recognizes as medically necessary only abortions required to avoid health detriments attributable to the enumerated conditions, either fully realized or demonstrably imminent." [Exc. 109] The catch-all category applies, the court found, only to "unspecified physical conditions of like gravity and imminence." [Exc. 109]

With this interpretation, the court concluded that AS 47.07.068 was no more constitutional than the coverage limits struck down in *Planned Parenthood 2001.* The court accepted Planned Parenthood's view that the new statute is "the Hyde Amendment in disguise": "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." [Exc. 111] The superior court applied this Court's decision in *Planned Parenthood 2001*—which found the Hyde-Amendment funding model to violate equal protection—and held that AS 47.07.068 violates equal protection for the same reasons. The superior court also struck down 7 AAC 160.900(d)(30) without separate analysis, commenting only that "[t]he mental health exception in the DHSS regulation is accordingly extremely limited." [Exc. 96] The court concluded that the only standard for Medicaid coverage of abortions permissible under this Court's decision in *Planned Parenthood 2001* is unfettered physician discretion to decide when an abortion is medically necessary. [Exc. 129-130] Consequently, the

superior court acknowledged, "as a practical matter . . . virtually all indigent Alaskan women seeking abortions will receive state Medicaid funding." [Exc. 130]

The State has appealed.

STANDARD OF REVIEW

The Court reviews the superior court's factual determinations for clear error.[39] It reviews constitutional issues de novo, adopting the most persuasive rule of law in light of precedent, reason, and policy.[40] It upholds a statute against a facial constitutional challenge if "despite any occasional problems it might create in its application to specific cases, [the statute] has a plainly legitimate sweep."[41]

ARGUMENT

Alaska Statute 47.07.068 provides an objective, reasonable standard for "medically necessary" abortions that permits funding if a physician determines that continuing a pregnancy threatens the woman's health. The statute requires the threat to be non-trivial but not, as the superior court found, "fully realized or demonstrably imminent." The superior court should not have adopted this narrow, rigid interpretation despite finding the statute to be ambiguous, but rather should have chosen the constitutional interpretation, which is supported both by the statute's plain language and the legislative history.

Correctly construed, the statute does not violate Alaska's equal protection clause.

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39 *State v. Planned Parenthood*, 171 P.3d at 581 (citing *Grimm v. Wagoner*, 77 P.3d 423, 427 (Alaska 2003)).

40 *State v. Planned Parenthood*, 171 P.3d at 581 (citing *Treacy v. Municipality of Anchorage*, 91 P.3d 252, 260 (Alaska 2004)).

41 *State v. Planned Parenthood*, 171 P.3d at 581 (citing *Treacy*, 91 P.3d at 260 n.14).

It covers medically necessary treatment according to a neutral standard, consistent with other Medicaid coverage. It does not directly infringe a constitutional right; it only limits state subsidies for non-medically necessary abortions. And it bears a fair and substantial relationship to Medicaid's goal of providing care to protect patients' health.

The superior court erred in finding that this Court has already dictated the result of this case—that Medicaid must pay for all abortions. To the contrary, in its 2001 Medicaid-funding decision the Court distinguished between medically necessary abortions and elective abortions. This Court should reaffirm that the Alaska Constitution does not require state payment for elective abortions, and should reverse the superior court's decision to the contrary.

I. The plain language of the statute defines "medically necessary" to delineate funding limits in an appropriate and constitutional manner, as the Legislature intended.

A. Under AS 47.07.068, the State will fund an abortion when a physician determines that a woman's condition indicates that continuing her pregnancy could put her at serious risk of physical impairment.

Alaska Statute 47.07.068 employs a broad and inclusive definition of when an abortion is medically necessary for purposes of Medicaid coverage. To qualify for reimbursement, the abortion must in the physician's judgment be necessary "to avoid a threat of serious risk to the life or physical health of a woman from continuation of the woman's pregnancy."[42] The statute defines serious risk to physical health to include "serious risk to the pregnant woman of . . . impairment of a major bodily function" due to

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42 AS 47.07.068(b)(3).

twenty-one listed conditions and a catch-all provision.[43] But the statute does not require the pregnant woman to actually have or be on the cusp of that condition to qualify for Medicaid coverage. Instead, an abortion is covered if the physician determines that continuing the pregnancy poses a "threat of" a condition that would place the woman at serious risk of impairment of a major bodily function. The statute gives the physician considerable discretion to make that determination so long as the physician is exercising "objective and reasonable professional judgment."

Given the statute's express attempt to distinguish medically necessary abortions from elective abortions,[44] "threat of serious risk to the life or physical health of a woman" does not mean the elevated health risk attributable solely to pregnancy. Although being pregnant is more risky than not being pregnant (all other things being equal), [Tr. 108-109], AS 47.07.068 does not authorize Medicaid coverage for all abortions on that basis alone. Yet a physician could "objective[ly] and reasonab[ly]" decide that a woman's history of preeclampsia in a prior pregnancy—which elevates her risk of preeclampsia in subsequent pregnancies—means that her pregnancy poses a "threat of serious risk" of "impairment of a major bodily function" due to "severe preeclampsia." [Tr. 53-54, 104] Likewise, a physician could objectively and reasonably conclude that given a diabetic patient's insecure housing situation and poor self-care—which are "medically relevant factors"—continuing her pregnancy poses a "threat of serious risk" of "impairment of a major bodily function" due to out-of-control diabetes. [Tr. 33, 483, 662] Thus the statute

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43 AS 47.07.068(b)(4).

44 AS 47.07.068(b)(2) & (3).

authorizes Medicaid to cover abortion for a wide range of ailments and conditions that elevate the risk pregnancy poses to a woman's health.

The statute does not authorize Medicaid coverage of abortions sought to alleviate mental health conditions associated with pregnancy, except in those cases where the pregnancy makes the woman suicidal. As discussed below, abortion is not a recognized treatment for mental illness.[45] The statute emphasizes that abortion is covered when pregnancy poses a threat of serious risk to a woman's "physical health," the listed conditions are all physical, and the catch-all provision is worded in terms of physical illness and conditions as well. But the statute does not limit conditions threatening a patient's life to physical conditions. A physician could reasonably conclude that a patient's active or past suicidal ideation means that continuing the pregnancy poses a "threat of serious risk to" her life, authorizing Medicaid coverage for an abortion.

The challenged regulation, 7 AAC 160.900(d)(30), is virtually identical to AS 47.07.068 except in its broader provision for mental health conditions. The regulation authorizes Medicaid coverage to "avoid a threat of serious risk to the physical health of the woman" due to "a psychiatric disorder that places the woman in imminent danger of medical impairment of a major bodily function if an abortion is not performed."[46] The regulation thus covers not only psychiatric disorders that threaten a woman's life, like depression with suicidal ideation, but also psychiatric disorders that threaten the woman's

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45 *See* Section II(C)(3), *infra.*

46 7 AAC 160.990(d)(30).

physical health—such as anorexia or self-neglect caused by depression or other mental illnesses—if the physician believes an abortion is needed to avoid these harms.

B. The superior court's interpretation of AS 47.07.068 ignored fundamental canons of construction and contravened the Legislature's intent.

The superior court rejected the State's interpretation of AS 47.07.068, accepting instead Planned Parenthood's much narrower view. It concluded "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." [Exc. 109] Specifically, it "only applies to situations where the woman's health is so compromised that, in general, she suffers a risk of death." [Exc. 111]

To arrive at this interpretation, the superior court flouted basic principles of statutory construction and constitutional law. It ignored the plain text of the statute—literally re-writing the operative text to make the statute more restrictive. It ignored its duty to give statutes a constitutional interpretation, instead giving it an interpretation that had already been held unconstitutional in *Planned Parenthood 2001*, even as it conceded that the statute was susceptible to the State's less restrictive interpretation. And it ignored legislative history showing the Legislature intended to craft the statute in a way that would satisfy the Court's holding in *Planned Parenthood 2001* by covering situations when pregnancy threatened not just a woman's life (the Hyde Amendment standard), but also her health more broadly. In doing so, the superior court all but accused the Legislature of throwing a fresh coat of paint on the statute enjoined in 2001 in an attempt to fool the courts, calling the provision to cover health risks "illusory" and concluding

that the Legislature, "[i]mpelled by . . . contrived testimony," "enacted a minimal tweak to the restrictive Hyde Amendment standard . . . ." [Exc. 111, 118] The superior court's accusation is at odds with the respect due a co-equal branch of government,[47] and its interpretation of AS 47.07.068 has little to recommend it.

1. The superior court's choice of a restrictive interpretation of AS 47.07.068—despite its finding that the statute is ambiguous—violated the presumption of constitutionality.

The statute was entitled to a presumption of constitutionality. A "well-established rule of statutory construction" requires courts "if possible [to] construe statutes so as to avoid the danger of unconstitutionality."[48] Not only are statutes presumed constitutional, but any doubts are resolved in favor of constitutionality.[49] This rule is based on the recognition "that the legislature, like the courts, is pledged to support the state and federal constitutions and that the courts, therefore should presume that the legislature sought to act within constitutional limits."[50] This rule also recognizes that "[d]ue respect for the legislative branch of government requires that [the Court] exercise [its] duty to declare a statute unconstitutional only when squarely faced with the need to do so."[51]

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47 *See State v. American Civil Liberties Union of Alaska*, 204 P.3d 364, 373 (Alaska 2009).

48 *Andrade*, 23 P.3d at 71.

49 *Alaskans for a Common Language, Inc. v. Kritz*, 170 P.3d 183, 192 (Alaska 2007).

50 *Id.* (citing *Kimoktoak v. State*, 584 P.2d at 31. *Kimoktoak* in turn relies on 2 Sutherland Statutory Construction, §4509, at 326 (Horack 3d Ed. 1943).

51 *State v. American Civil Liberties Union*, 204 P.3d at 373.

The superior court thus should have interpreted the statute so as to avoid constitutional problems, not to create them.[52] Instead, the court actively facilitated an unconstitutional interpretation by *changing* the statutory text. Although the statute is written to allow Medicaid reimbursement for abortions that a physician considers necessary "to avoid a threat of serious risk to the . . . physical health of a woman" from any physical disorder, injury or illness that places the woman in danger of major bodily impairment, the court changed the language to mean that the health conditions cited in the statute must be "either fully realized or demonstrably imminent." [Exc. 109] The court did this by adding the word "consisting" to diminish the significance of the word "threat." [Exc. 109] Deciding that "[t]he word 'threat' in the statute must be taken as a mere reiteration of the phrase 'serious risk,'" the court concluded that "[r]ead thusly the statute addresses 'a threat [consisting] of a serious risk to the physical health of the woman,' and not merely possible remote risks.'" [Exc. 109] But a court may not "read into a statute that which is not there, even in the interest of avoiding a finding of unconstitutionality."[53] That prohibition surely applies with even greater force when the words read into the statute *create* a finding of unconstitutionality.

2. The superior court improperly interpreted AS 47.07.068 by relying too heavily on the legislative history and by viewing it selectively rather than examining it as a whole.

The superior court ruled that "the legislative history is consistent only with a hard-

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52 *Alaskans for a Common Language*, 170 P.3d at 192 (citing *State, Dep't of Revenue v. Andrade*, 23 P.3d 58, 71 (Alaska 2001)).

53 *Alaskans for a Common Language*, 170 P.3d at 192.

core standard based on definitive bright lines." [Exc. 108] The court acknowledged that the Legislature "nominally add[ed] a health endangerment component to its definition of medical necessity," but the court did not believe that the Legislature actually intended to expand the coverage that the 2001 regulation provided. [Exc. 111] The court reasoned that "[t]he 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." [Exc. 111]

This conclusion is problematic for several reasons. First, the statute's unaltered text is not ambiguous, so the court's use of the legislative history as the determinative factor was improper. Second, the court mischaracterized the import of selected testimony and failed to recognize the intent shown in the legislative history overall.

Statutory interpretation in Alaska begins with the plain meaning of the statute's text.[54] While legislative history can inform a statute's meaning, under this Court's approach to statutory interpretation, a statute's plain language remains significant: the clearer the statutory language is, the more convincing the legislative history must be to justify another interpretation.[55] The superior court's need to tinker with the statutory text to make it support Planned Parenthood's restrictive reading refutes its assertion that AS 47.07.068 is susceptible to each party's interpretation. [Exc. 109] Unaltered, the text supports the State's interpretation, so the court should not have relied heavily on the

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54 *Ward v. State, Dep't of Public Safety*, 288 P.3d 94, 98 (Alaska 2012) (citing *City of Kenai v. Friends of Recreation Ctr., Inc.*, 129 P.3d 452, 458-59 (Alaska 2006)).

55 *Ward*, 288 P.3d at 98 (citing *Bartley v. State, Dep't of Admin., Teacher's Ret. Bd.*, 110 P.3d 1254, 1258 (Alaska 2005)).

statute's legislative history to buttress its contrary, unconstitutional, reading.

But in any event, the legislative history supports the State's interpretation of the statute. First and foremost, the legislative history is crystal clear on one point: the purpose of the bill was to enact a law that would constitutionally define "medically necessary" under *Planned Parenthood 2001*. The Legislature understood that the bill could not merely be another version of the Hyde Amendment regulation. The sponsor of the bill explained it to legislators not as "a minimal tweak to the restrictive Hyde Amendment standard" (in the court's words), but rather as a way to eliminate elective abortions from Medicaid funding while still covering abortions needed to maintain the health of a woman, consistent with the Alaska Constitution.

Introducing the bill to the Senate Finance committee, for example, the sponsor described the extensive input received on a proper standard—including legal advice, medical advice, and public input[56]—and stated that the resulting bill "describe[s] medical necessity, still giving leeway to the doctors for the professional decision-making" and "defin[es] what is the physical criteria for the life and health, wellbeing of the mother."[57]

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[56] In the sponsor's words:

> We had a thorough vetting down in judiciary with three national experts, medical experts, with regards to abortions across the country talk on the subject. We had seven to eight doctors from Alaska. We had the public come in and give their testimony. We had pro-choice doctors, we had the ACLU, we had Planned Parenthood, we gave everybody a thorough chance to review the bill up to this point, and we're, we're confident in the language we have included because it's been thoroughly vetted by both medical experts and legal experts.

Senate Finance Comm. Audio Links for March 29, 2013, 28th Leg., at 21:19, found at http://www.akleg.gov/ftr/2013/20130329/sfin/sfin_0908.mp3 (last visited April 12, 2016).

[57] *Id.* at 8:40.

He stated that the bill had criteria both for the Hyde Amendment standard *and* for conditions that create a risk to a woman's health, noting that it included "the life/health risk . . . physical health risk, and [that it] give[s] the doctor discretion."[58] Continuing the introduction, the sponsor's staff person explained that the bill included protections required by the Alaska Constitution.[59] He explained that the bill was consistent with the Alaska Constitution because it "includ[es] provisions that say that it is not . . . limited to the conditions we have listed here and it includes the physical health of the mother, so that's one extra layer above and beyond just life threatening circumstances with the mother or in the cases of rape or incest."[60]

The legislator responsible for the bill thus explained that its intent was to define "medically necessary" in a way that is consistent with this Court's *Planned Parenthood 2001* decision. The superior court's skepticism might be warranted if the statutory language did not reflect this intent, but even the superior court acknowledged that it was "susceptible" to this interpretation.

Instead of crediting the Legislature's stated intent and purpose, the superior court plucked statements from the legislative history that, at first blush, seem to support the contrary view. "Judicial investigation of legislative history has a tendency to become . . . an exercise in 'looking over a crowd and picking out your friends.'"[61] That appears to be

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58 *Id.* at 11:43.

59 *Id.* at 14:48.

60 *Id.* at 15:01.

61 *Exxon Mobil Corp. v. Allapattah Services, Inc.*, 545 U.S. 546, 568-569 (2005) (quoting Wald, "Some Observations on the Use of Legislative History in the 1981 Supreme Court Term," 68 Iowa L. Rev. 195, 214 (1983)).

what happened here, with the superior court's legislative history analysis relying primarily on statements made by physician John Thorpe, who explained that the conditions listed in the bill were sufficiently serious that abortion would be recommended as a treatment even for women who wanted to continue their pregnancies. [Exc. 85, 108]

Yet Dr. Thorpe's statement is not inconsistent with the State's interpretation of the statute. The superior court's focus on Dr. Thorpe's testimony about the seriousness of the listed conditions is misleading, because his testimony did not touch on the other elements of the statute—specifically, the "threat of a serious risk" language that authorizes coverage for an abortion if a pregnant woman has an identifiable risk of developing a listed medical condition. Nor did Thorpe discuss the catch-all provision, which further broadens the statute's coverage. This is not surprising, as Dr. Thorpe was a medical expert, not a legal one: his role was to identify medical conditions for which abortion is considered a treatment, not to advise about how to make the statute constitutional. But even if Thorpe's testimony somehow contradicted the State's interpretation of the statute, it would not change the final analysis: the statements of a non-lawyer witness do not outweigh the statements of the legislators who passed the bill in determining what the bill means. Thus, even if this Court considers the legislative history of AS 47.07.068, that history supports the State's interpretation of the statute as one authorizing broad Medicaid coverage for abortions needed to protect a pregnant woman's health.

II. The statute, properly construed, does not violate the equal protection clause of the Alaska Constitution.

The superior court's equal protection analysis turns on its erroneous belief that

AS 47.07.068 is a mere "tweak[]" to the Hyde Amendment standard this Court rejected in *Planned Parenthood 2001*. And the superior court's equal protection analysis is flawed in other basic ways as well.

First, the superior court concludes that unfettered physician discretion is the only constitutionally permissible standard for Medicaid coverage of abortions. In arriving at this conclusion the superior court not only drew unwarranted inferences from the cases cited in *Planned Parenthood 2001*, it also dismissed as essentially meaningless this Court's express distinction between elective abortions and abortions needed to protect a woman' s health.[62] But presumably the Court did not intend to draw a meaningless distinction, and its decision does not in any way preclude the Medicaid program from using a standard that effectively distinguishes between the two.

Second, the superior court concluded that excluding coverage for abortions sought out of distress at an unwanted pregnancy was inconsistent with what it viewed as the Medicaid program's generous provision for its beneficiaries' physical and emotional well-being. Yet the superior court failed to recognize that Medicaid is limited to meeting essential health needs; it is not a program that provides any care that would optimize beneficiaries' well-being. The coverage limits drawn by AS 47.07.068 are therefore fairly and substantially related to Medicaid's purpose of protecting poor Alaskans' basic health.

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62 28 P.3d at 905.

A. *Planned Parenthood 2001* does not preclude the State from articulating a standard for distinguishing between medically necessary and elective abortions.

Based largely on *Planned Parenthood 2001*, the superior court concluded that the State must pay for an abortion whenever a physician determines it is medically necessary and may not guide the physician's discretion in any way. [Exc. 129] The court conceded that "as a practical matter virtually all indigent Alaskan women seeking abortions will receive state Medicaid funding." [Exc. 129-30] Although some language in *Planned Parenthood 2001* could be read to support this conclusion, to do so one would have to conclude (as the superior court did) that the Court's express distinction between medically necessary and elective abortions was meaningless.

The superior court began with the premise that the conditions mentioned in the opening passages of *Planned Parenthood 2001* definitively outline the scope of medically necessary abortions, inferring this Court's "intolerance" of subjecting indigent women to any "material health detriments, or to mental distress due to serious fetal anomalies." [Exc. 120-121] Yet as this Court is aware, the scope of a public benefits program and the degree to which it attempts to alleviate the distress caused by poverty and other circumstances is a policy decision for the Legislature; *Planned Parenthood 2001* cannot reasonably be understood to set an absolute bar. If a benefits program treats its beneficiaries equally, the Court cannot require more, however humane its impulses.

Nor was the Court's 2001 description of conditions for which an abortion might be medically necessary based on objective medical literature or vetted through the trial process. Instead, The Court's list was drawn almost verbatim from the affidavit of one of

Planned Parenthood's physicians in that case, which was decided on summary judgment and did not turn on the question of when an abortion is medically necessary. [Exc. 1-5] This case does present that question, so the Court should evaluate the evidence and justifications presented here rather than believing itself bound by dicta in a prior decision. This is especially true because the 2001 opinion's passage effectively collapses the distinction between medically necessary and elective abortions, even as the decision expressly recognized that distinction. If an abortion is medically necessary because a woman's inability to pay for it early in her pregnancy will result in her getting a riskier (but still objectively safe [Tr. 506]) abortion later in pregnancy, then every pregnancy sought by a low-income woman is medically necessary, regardless of her medical condition or reason for getting it. Unless the Court's statement that its decision "does not concern State payment for elective abortions"[63] is meaningless, the passage describing abortions that might be medically necessary cannot be treated as gospel.

The superior court also erred in the conclusions it drew from other state court decisions cited in *Planned Parenthood 2001*. The superior court suggested that this Court would follow the lead of the other courts in "rejecting a high-risk high-hazard standard." [Exc. 124] But those cases involved either state-level Hyde Amendment standards or state

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63 28 P.3d at 905.

statutes that covered abortion for only the most severe health conditions.[64] Because Alaska's statute is different—its relatively permissive coverage standard tracks the line between abortions needed to protect a woman's health and elective abortions—those decisions have little bearing on the constitutionality of this statute. As for other courts' "approval of virtually unfettered physician discretion," the superior court failed to recognize that at least some of the decisions it cited did not rule that unfettered physician discretion is constitutionally *required*. Some courts merely re-instated coverage standards that were previously in effect as a remedy for striking down the Hyde-like restrictions that

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64 *Women of State of Minn. by Doe v. Gomez*, 542 N.W.2d 17, 23-24 (Minn. 1995) (quoting Minn. St. § 256B.0625, subd. 16 (1994) (covering only abortions that are a "medical necessity," defined as "the signed written statement of *two physicians* indicating the abortion is medically necessary to prevent the death of the mother," or in cases of rape or incest))); *Moe v. Secretary of Administration and Finance*, 417 N.E.2d 387, 392 (Mass. 1981) ("The restriction was in a form similar to the Hyde Amendment; a rider to the State's Medicaid appropriations . . . prohibited State reimbursement for abortions except when necessary to prevent the death of the pregnant woman or in certain cases of rape or incest."); *Com. to Defend Reproductive Rights v. Myers,* 625 P.2d 779, 782 (Cal. 1981) (budget provisions provide funding for abortions "only (1) when pregnancy would endanger the mother's life; (2) when pregnancy would cause severe and long-lasting physical health damage to the mother; (3) when pregnancy is the result of illegal intercourse . . . ; or (4) when abortion is necessary to prevent the birth of severely defective infants."); *Right to Choose v. Byrne,* 450 A.2d 925, 927 (N.J. 1982) (statute prohibited funding for abortions "except where it is medically indicated to be necessary to preserve the woman's life" (quoting N.J.S.A. 30:4D-6.1 (1981))); *New Mexico Right to Choose/NARAL v. Johnson*, 975 P.2d 841 (N.M. 1998) (regulation prohibited funding for abortions except when necessary to save the life of the mother, to end ectopic pregnancy, or when the pregnancy resulted from rape or incest (citing 8 N.M. Admin. Code 4.MAD.766 (May 1, 1995)); *Women's Health Ctr. of W. Va., Inc. v. Panepinto*, 446 S.E.2d 658 (W. Va. 1993) (statute prohibiting abortion funding except in cases of medical emergency when abortion needed to avert death or irreversible loss of major bodily function, when pregnancy is result of rape or incest, or when fetus has severe congenital defects or is not expected to survive (citing W. Va. Stat. § 9-2-11 (Supp. 1993)).

replaced them.[65] In a similar vein, the New Jersey Supreme Court ruled that the state's version of the Hyde Amendment must be read to cover all medically necessary abortions to satisfy New Jersey's constitution, yet expressly recognized that it would be legitimate for state officials to guide physicians' determination of medical necessity by regulations "consistent with competent medical treatment."[66] In sum, neither *Planned Parenthood 2001* nor the cases it relied on preclude the Court from upholding the statute at issue here.

B. Strict scrutiny does not apply to the coverage limitations.

Perhaps because the superior court viewed AS 47.07.068 as a mere "tweak" to the regulation struck down in *Planned Parenthood 2001*, it ruled the statute unconstitutional without deciding what level of scrutiny applies. Yet the first step in equal protection analysis is deciding what level of scrutiny to apply to the challenged statute.[67] Here, strict scrutiny does not apply to the statute's Medicaid funding limitations because they do not "directly infringe a fundamental right,"[68] nor do they "selectively deny[] benefits to those who exercise a fundamental right."[69]

Although *Planned Parenthood 2001* applied strict scrutiny to a regulation that provided Medicaid funding for abortions only in cases of risk of death, of rape, or of

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65 *See N.M. Right to Choose/NARAL v. Johnson*, 975 P.2d at 844; *Women's Health Ctr. of W. Va., Inc. v. Panepinto*, 446 S.E. at 661 n.3, 667.

66 *Right to Choose v. Byrne*, 450 A.2d at 938 (ruling that state's version of Hyde Amendment could survive constitutional scrutiny only with "coverage extended to medically necessary abortions," but—recognizing legislature's desire not to fund elective abortions—holding that physicians could be guided in the determination of medically necessary by regulations "consistent with competent medical treatment.").

67 *Planned Parenthood 2001*, 28 P.3d at 909.

68 *State v. Planned Parenthood of Alaska*, 35 P.3d 30, 42 (Alaska 2001).

69 *Planned Parenthood 2001*, 28 P.3d at 909.

incest,[70] it does not automatically follow that strict scrutiny applies here. The Court explained that strict scrutiny applies when "the government, by selectively denying a benefit to those who exercise a constitutional right, effectively deters the exercise of that right."[71] It reasoned that although the State is not required to provide "limitless health services to all poor Alaskans," it is "constitutionally bound to apply neutral criteria in allocating health care benefits."[72] The State may not limit expenditures with "invidious distinctions between classes of its citizens."[73] The Court relied on its own decision in *Alaska Pacific Assurance v. Brown* and the U.S. Supreme Court's decision in *Shapiro v. Thompson*, both of which applied strict scrutiny to laws denying benefits to all people who had exercised their constitutional right to interstate travel.[74] In *Alaska Pacific Assurance*, for example, the challenged statute reduced workers' compensation benefits for workers who exercised their constitutional right to leave the state.[75] In the Medicaid context, the Court reasoned that denying funding for all medically necessary abortions (except to save the mother's life) was similar because Medicaid benefits otherwise available for medically necessary treatment were restricted for women who exercised their right to an abortion.[76] The Court therefore held that strict scrutiny applied.[77]

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70 *Id.* at 909-10.

71 *Id.* at 909.

72 *Id.* at 910.

73 *Id.* (quoting *Shapiro v. Thompson*, 394 U.S. 618, 633 (1969)).

74 *Id.* at 910-11 (citing *Alaska Pacific Assurance Co.*, 687 P.2d 264, 273-74 (Alaska 1984); *Shapiro v. Thompson*, 394 U.S. at 633).

75 687 P.2d 264.

76 28 P.3d at 909-10 (citing *Alaska Pacific Assurance Co.*, 687 P.2d at 266-67).

77 28 P.3d at 910-11.

But AS 47.07.068 is unlike the enactments in *Planned Parenthood 2001*, *Alaska Pacific Assurance*, and *Shapiro v. Thompson* because it does not selectively deny Medicaid benefits to women who exercise their right to terminate a pregnancy. Rather, Medicaid will pay for an abortion so long as it meets the across-the-board requirement for all Medicaid services—that the service is needed to protect the patient's health.[78] The Court noted in *Planned Parenthood 2001* that the "necessity of particular services" is a permissible standard to limit public benefits.[79]

Although most services in the Medicaid program are not subject to specialized standards of medical necessity, Medicaid does apply specialized standards or procedures for determining the medical necessity of some procedures that are often sought even if not necessary to protect a patient's health—a fact the superior court's opinion largely ignores.[80] Different procedures are necessary in different situations, so a standard of necessity specific to abortions is not automatically invidious. Because AS 47.07.068 is not an "invidious distinction[] between classes of [] citizens," but rather is an attempt to tailor the "neutral criter[ion]" of medical necessity—a universal Medicaid requirement—to the specific case of abortions, the statute does not trigger strict scrutiny.

The Court also stated in *Planned Parenthood 2001* that strict scrutiny applies when

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78 7 AAC 105.100(5); 7 AAC 105.110(1).

79 28 P.3d at 910.

80 *E.g.*, 7 AAC 135.020(a) (necessity criteria for behavioral health services); 7 AAC 105.110(4) (necessity criteria for reconstructive surgery); 7 AAC 110.153 (necessity criteria for orthodontia); 7 AAC 125.020(a)-(c) (necessity criteria for personal care attendant); 7 AAC 130.205(d) (necessity criteria for waiver services).

a statute "affects the exercise of a constitutional right,"[81] but this dictum—to which the Court devoted a mere paragraph—is a misstatement of the correct test for strict scrutiny in equal protection claims: whether the State's action "*directly* infringes a fundamental right."[82] This dictum should not be given the controlling weight the superior court gave it because doing so would have significant, likely unintended impacts well beyond this case. First, a rule that applies strict scrutiny whenever a law "affects the exercise of a constitutional right" would completely eclipse the "selective discrimination" standard developed in the rest of *Planned Parenthood 2001*'s analysis. Any enactment that that "selectively den[ies] a benefit to those who exercise a constitutional right, effectively deter[ring] the exercise of that right," will invariably also "affect[] the exercise of a constitutional right." It seems unlikely that the Court intended to create two separate tests for strict scrutiny, one that entirely encompasses the other. More likely, the Court simply neglected to add the key qualifier "directly" to its recitation of the test.

Indeed, the cases the Court cited in 2001 do not directly support the proposition that strict scrutiny applies any time a statute "affects" a fundamental right. *State v. Ostrovsky* recited the general standards for equal protection but did not involve a classification burdening a fundamental right.[83] *Valley Hospital Association* provides even less support for the trial court's expansive interpretation of this Court's equal protection

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81 28 P.3d at 909.

82 *State v. Planned Parenthood of Alaska*, 35 P.3d at 42 (parental consent act case) (emphasis added).

83 667 P.2d 1184, 1193 (Alaska 1993) ("The individual interest asserted in Ostroskys' challenge . . . is not of a high order.").

standards because it was decided on privacy, not equal protection grounds.[84] It does not support the proposition that, when an equal protection claim is raised, strict scrutiny applies to any differential treatment that "affects" a fundamental right.[85]

Nor have this Court's cases decided after *Planned Parenthood 2001* suggested that that decision fundamentally broadened Alaska's equal protection jurisprudence. The Court has applied strict scrutiny only to laws that directly infringe fundamental rights. In *Treacy v. Municipality of Anchorage*, for example, the Court applied strict scrutiny to a municipal curfew that restricted minors' freedom of movement.[86] In *State v. Planned Parenthood*, the Court affirmed that strict scrutiny applied to a law requiring minors to obtain parental consent to an abortion.[87] By contrast, AS 47.07.068 does not directly infringe a woman's right to have an abortion; it limits only state subsidies for abortion, which have never been recognized as a fundamental right by this or any other court.

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84 *Valley Hosp. Ass'n, Inc. v. Mat-Su Coal. for Choice*, 948 P.2d 963 (Alaska 1997). Nor does *Valley Hospital* mean that the funding restriction is subject to strict scrutiny on privacy grounds. As the Court has clarified in subsequent cases, strict scrutiny applies "when a law places substantial burdens on the exercise of a fundamental right." *Huffman v. State*, 204 P.3d 339, 346-47 (Alaska 2009) (quoting *Myers v. Alaska Psychiatric Institute*, 38 P.3d 238, 246 (Alaska 2006)). Declining to provide subsidies for the exercise of constitutional rights does not place a substantial burden on the exercise of those rights. If it did, strict scrutiny would apply to the State's failure to subsidize constitutional rights of all kinds—rights to travel, speech, and own a firearm. The difficulty of analyzing limits on Medicaid coverage of abortion as a violation of the right to privacy may be why the superior court did not rule on Planned Parenthood's privacy claim. [Exc. 25]

85 Nor would *Valley Hospital* be analogous even if it were viewed through the lens of equal protection. That case involved a statute allowing hospitals and health care providers to opt out of providing abortions for reasons of conscience: a unique burden placed only on abortion. 948 P.2d at 971-72. *Valley Hospital* is simply inapposite.

86 91 P.3d at 265-66.

87 *State v. Planned Parenthood of Alaska*, 35 P.3d at 45.

Adopting a rule that applies strict scrutiny whenever a law "affects" a fundamental right could affect the scope of the Medicaid program well beyond its coverage for abortions. Alaskans' right of privacy covers more than deciding whether to terminate a pregnancy: "[t]he right to make decisions about medical treatments for oneself or one's children is a fundamental liberty and privacy right in Alaska."[88] Many other medical decisions—including whether to seek infertility treatment, whether to have a preemptive double mastectomy, whether to try a novel therapy for mental illness, whether to pursue gender re-assignment surgery, whether to take expensive new drugs for Hepatitis-C—involve the same supremely personal interest in "control of [one's] body."[89] If any limit on Medicaid funding for these treatments is subject to strict scrutiny—and if reasons like "medical necessity, cost, and feasibility"[90] are not sufficiently compelling to satisfy that scrutiny—then the State's ability to control the scope of the Medicaid program will be substantially curtailed. The Court's equal protection analysis therefore must distinguish between laws that directly infringe constitutional rights and those that merely affect the exercise of these rights by limiting state subsidies. Alaska Statute 47.07.068 is a case of the latter. And because it merely attempts to flesh out Medicaid's generally applicable

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88 *Huffman*, 204 P.3d at 346.

89 *Valley Hospital*, 948 P.2d at 968 (quoting *Breese v. Smith*, 501 P.2d 159, 169 (Alaska 1972)).

90 28 P.3d at 910. This Court has suggested that cost savings alone are not a compelling interest. *See Alaska Pac. Assur. Co. v. Brown*, 687 P.2d at 272 ("Although reducing costs to taxpayers or consumers is a legitimate government goal in one sense, savings will always be achieved by excluding a class of persons from benefits they would otherwise receive. Such economizing is justifiable only when effected through independently legitimate distinctions.").

standard in the specific case of abortions—not to invidiously discriminate against women who choose to terminate a pregnancy—the substantial relationship test applies.

C. The coverage limitations bear a fair and substantial relationship to the Medicaid program's purpose of providing care that is necessary to protect patients' health.

"Under Alaska's rational basis standard, differential treatment of similarly situated people is permissible only if the distinction between the persons 'rest[s] upon some ground of difference having a fair and substantial relation to the object of the legislation.'"[91] Put differently, "classification among recipients must be based on some difference between the classes which is pertinent to the purpose for which the legislation is designed."[92] The basic purpose of the Medicaid program is to provide medical care to the indigent.[93] Medicaid will pay only for care that is "medically necessary,"[94] and will not pay for any care that is "not reasonably necessary for the diagnosis and treatment of an illness or injury, or for the correction of an organic system . . . ."[95] Thus the key question is whether the classifications created by the statute—representing an attempt to distinguish between abortions needed to protect a woman's health and those that are not—are substantially related to the Medicaid program's legitimate purpose of paying for medical care necessary to protect its beneficiaries' health.

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91 *Planned Parenthood 2001*, 28 P.3d at 911.

92 *Id.* at 912.

93 AS 47.07.020(a).

94 7 AAC 105.100(5).

95 7 AAC 105.110(1).

1. Medically necessary abortions v. elective abortions

The statute expressly distinguishes between medically necessary abortions, which Medicaid will pay for, and elective abortions, which Medicaid will not.[96] Drawing a line between abortions necessary to protect a woman's health and abortions sought to further other life goals with only tangential (if any) relation to the patient's health is consistent with Medicaid's general rule denying coverage for services or procedures that are "not reasonably necessary for the diagnosis and treatment of an illness or injury, or for the correction of an organic system . . . ."[97]

Planned Parenthood's witnesses suggested at trial that it is impossible to draw a meaningful distinction between medically necessary and elective abortions. [Tr. 124-25; 256-57; 377] But this Court has concluded otherwise, expressly distinguishing between the two.[98] As the New Jersey Supreme Court recognized in its decision on Medicaid funding for abortions (a decision this Court cited with approval in its 2001 opinion), a State "may draw a rational distinction between medically necessary abortions and nontherapeutic abortions that do not implicate the health of the mother. . . . That conclusion is consistent with the essential purpose of Medicaid, which is to provide necessary medical care for the indigent."[99] And although Planned Parenthood's witnesses rejected the concept of "medically necessary" as a meaningful standard for abortion

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96 AS 47.07.068(b).

97 7 AAC 105.110(1)

98 *Planned Parenthood 2001*, 28 P.3d at 905.

99 *Right to Choose v. Byrne*, 450 A.2d at 935 n.6 (cited in 28 P.3d 905 n.2).

care—testifying instead that every abortion is "medically *indicated*" if a woman desires one—they conceded that the term "medically necessary" is often used by insurance companies to determine coverage limits. [Tr. 34, 818] Nor did they suggest that insurance companies are unreasonable to apply a different lens than they use as treating physicians. Although doctors understandably would prefer that insurance companies cover everything that doctors believe will "result in a better outcome" for a patient, [Exc. 88], that is simply not the way insurance, public or private,[100] works in this country. Thus the physicians' testimony that all abortions are medically *indicated* from a patient-care perspective does not mean that Medicaid—a government health insurance program for the indigent—cannot use a different standard and cover only abortions that are medically *necessary*.

The statute distinguishes between medically necessary and elective abortions using the risk that pregnancy poses to a woman's health. Every pregnancy presents some risk to the pregnant woman's health, so a standard like the judicially-imposed standard in effect before AS 47.07.068 would—and in practice does—result in Medicaid funding for every abortion. [Exc. 129-130] The statute sets the bar a little higher, covering abortions if the physician determines that continuing the pregnancy poses a threat of suffering a serious health problem—the kind of problem that poses a serious risk of impairment of a major bodily function, like severe preeclampsia, out-of-control diabetes, or similar conditions.

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[100] In fact, the private insurance company that covers State of Alaska employees also denies coverage for abortions that are not medically necessary, which included most abortion claims processed. Testimony of Dep. Commissioner of Administration Michael Barnhill, House Fin. Com. Audio for February 25, 2014, 28th Leg., at 5:25, http://www.akleg.gov/ftr/2014/20140225/hfin/hfin_1333.mp3 (viewed April 14, 2016).

This standard allows considerable discretion, so long as the physician relies on relevant medical factors and exercises the standard in an "objective and reasonable" way.[101]

A doctor's assessment of relevant medical factors is critical to the distinction between medically necessary and elective abortions. An insurer cannot give the patient authority to decide for herself whether medical treatment is warranted; it needs an evaluation standard that separates patients' personal preferences from objective medical risk factors. For example, a low-income woman with two children may not want a third because the added expense would be challenging. Another woman in exactly the same situation may welcome a third child. From a medical standpoint, the first woman's distress about an unwanted pregnancy does not distinguish her from the second, and applying an objective medical analysis, an insurer would not find either woman eligible for coverage for a medically necessary abortion. Conversely, a woman with lower-level heart dysfunction may want an abortion to avoid the risk of developing class IV heart disease, while another with exactly the same condition might consider the risk to be acceptable and decide to continue her pregnancy. An insurer would find them equally eligible for coverage for a medically necessary abortion, regardless of their personal decisions about risk. The superior court reasoned that because doctors typically take patients' life circumstances into account, Medicaid must do so too, making a "rigid"—i.e. articulable—standard for medically necessary "impractical." [Exc. 129] Yet the superior court confuses the physician's role to offer what is medically indicated—anything that

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101 AS 47.07.068(b)(3).

"would result in some benefit to the patient" [Exc. 120]—with the insurer's role to cover what is medically necessary.[102]

The superior court's conclusion that Medicaid is "titrated with such exacting rigor" in "no other context" [Exc. 116] is based on its fundamental misreading of the statute. Indeed, the very situations that the superior court offered as examples of unacceptable gaps in coverage fall well within the statute's scope of coverage. The superior court concluded that because the statute uses the term "severe congenital or acquired heart disease, class IV," a woman who suffers from less severe heart disease would not be covered. But the testimony showed that even mild heart disease can be significantly aggravated by pregnancy.[103] [Tr. 705] In fact, the superior court expressly found that a young woman might have "a relatively asymptomatic heart defect"—i.e., class I or II heart disease [Tr. 705]—"that tips into florid symptoms during pregnancy, entailing a risk of death." [Exc. 91] For this very reason, a physician could reasonably conclude that a woman with asymptomatic or class I heart disease suffers a "threat of a serious risk" of "impairment of a major bodily function because of" class IV heart disease, even if at that point in her pregnancy she has experienced only slight or no deterioration in her

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102 *See, e.g.,* Exc. 129: "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."

103 The superior court observed that the State's witness, Dr. Calvin, "testified that a pregnancy can permanently advance a woman's functional capacity class by one level." [Exc. 112] But Dr. Calvin did not testify that pregnancy can cause heart disease to permanently advance by *only* a single level. [Tr. 705] Moreover, Dr. Calvin testified that during pregnancy, a woman's heart condition could experience "severe worsening, including the possibility of it becoming life threatening." [Tr. 650]

condition. In that case the physician can classify the abortion as medically necessary.

A similar dynamic is at play with other common conditions that complicate pregnancy. The superior court found that the most common health problem affecting pregnant women is obesity. [Exc. 88] Obesity puts a woman at relatively high risk of suffering preeclampsia, and she is also at elevated risk of postpartum hemorrhage, infection, and deadly blood clots. [Exc. 89] Thus a doctor could reasonably conclude that an obese patient faces a "threat of a serious risk" of "impairment of a major bodily function because of" severe preeclampsia or other conditions. Similarly, a woman who experienced preeclampsia in a prior pregnancy has an elevated risk of preeclampsia in successive pregnancies, [Exc. 88], so she too would fall within the statute's coverage.

The superior court found that social factors—such as insecure housing—might increase the health risks to a pregnant woman suffering diabetes, placing her at greater risk of being unable to manage her disease. [Exc. 92] A doctor, considering "medically relevant factors" like the patient's ability to manage her condition, could reasonably conclude that her inability to control her diabetes in pregnancy places her at "threat of a serious risk" of "impairment of a major bodily function because of" "diabetes with severe end-organ damage." The superior court's finding that the statute only captures "the tip of the iceberg" is incorrect because it ignores the attenuation of risk in the phrase "threat of a serious risk to . . . physical health" and the discretion that the statute gives to doctors.

The superior court also concluded that excluding abortions sought merely to alleviate a woman's distress at an unwanted pregnancy was inconsistent with what the court asserted to be Medicaid's purpose of "reliev[ing] human suffering." [Exc. 116] But

Medicaid generally does not cover treatment sought solely to alleviate distress caused by life's circumstances, short of actual diagnosed mental disorders. Medicaid is limited to providing care that protects people's basic health and does not provide all care that would optimize patients' physical or mental wellbeing.[104] For example, although many people's well-being might be improved by therapy or counseling, Medicaid covers behavioral health clinic services for adults only if they are experiencing a "serious mental illness" or an "emotional disturbance"[105]—defined as a "non-persistent mental, emotional, or behavioral disorder . . . identified and diagnosed during a professional behavioral health assessment."[106] Similarly, Medicaid covers behavioral health rehabilitation services for adults only if they have substance abuse problems or are experiencing a serious mental illness[107] and only when these services are identified as a needed treatment by a professional behavioral health assessment.[108] Medicaid does not cover nonsurgical weight reduction treatment programs, nonmedical fitness maintenance centers and services, or alternative therapies such as acupuncture or homeopathic remedies—even though these might enhance the overall health and well-being of the Medicaid population.[109] And

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104 *See* 7 AAC 105.110(1) (services not eligible for Medicaid coverage if "not reasonably necessary for the diagnosis and treatment of an illness or injury, or for the correction of an organic system . . . .").

105 7 AAC 135.020(a).

106 7 AAC 135.990(3).

107 7 AAC 135.020(b).

108 7 AAC 135.010(a)(3).

109 7 AAC 105.110(11), (13-15), (17).

infertility treatment is not covered at all,[110] even though the inability to bear a child may be as distressing to some women as an unwanted pregnancy is to others.

The superior court's examples of Medicaid services that "relieve[] human suffering" do not refute this general standard for Medicaid coverage. The superior court's mention of "behavioral counseling for the family of errant youth"—presumably a reference to "therapeutic behavioral health services for children"[111]—fails to note that Medicaid will cover these services only if the child has been diagnosed with a "severe behavioral disorder."[112] Nor is there any indication that these services are targeted at relieving the distress of the child's family members, as the superior court suggests; covered services are specifically "for children"[113] and family is presumably involved in the child's therapy for the *child's* benefit. The court also mentioned Medicaid coverage for surgical repair of disfigurements without noting applicable coverage limitations: these procedures are funded at public expense only when needed for "repair of an injury; improvement of the functioning of a malformed body member; [or] correction of a visible disfigurement that would materially affect the recipient's acceptance in society."[114] In other words, reconstructive surgery is not authorized solely because a disfigurement is distressing to the patient; it must rise to the level of a disability. The court also offered the example of Medicaid covering breast reconstruction surgery, specifically a tattoo of a

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110 7 AAC 105.110(10).
111 7 AAC 135.220.
112 7 AAC 135.220(a).
113 7 AAC 135.220(b).
114 7 AAC 105.110(4).

nipple on a reconstructed breast. [Exc. 116] Yet Medicaid's coverage for complete breast reconstruction after a mastectomy (which certainly qualifies as the "repair of an injury") rather than covering only a half-completed surgery does not eviscerate an otherwise discernable line between procedures necessary for basic health and procedures that might relieve emotional distress[115]—a line that AS 47.07.068 traces.

2. Abortion v. other pregnancy-related care.

By articulating a standard of medical necessity specific to abortion, AS 47.07.068 creates a distinction between abortion and other pregnancy-related medical care. But this distinction too is related to Medicaid's purpose of covering medically necessary treatment. As this Court recognized in *Planned Parenthood 2001*, at least some women seek abortions for reasons other than to protect their health.[116] Planned Parenthood's witnesses did not hide the fact that many of their patients seek abortions for non-medical reasons, such as not wanting to be tied to an abusive spouse; wanting to continue a certain educational trajectory; or concern over the financial stress of raising another child. [Exc. 98-100] In this respect, abortion is distinct from other pregnancy-related care like ultrasounds or hospital delivery, medical interventions that almost always serve to protect the health of the woman or fetus. But there are other types of pregnancy-related care that

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115 *See Commercial Fisheries Entry Comm'n v. Apokedak*, 606 P.2d 1255, 1267 (Alaska 1980) (". . . [E]qual protection, even under Alaska's stricter standard, does not demand perfection in classification. If it did, there would be few laws establishing classifications that would sustain an equal protection challenge.").

116 28 P.3d at 905.

are not always needed to protect health, like nutrition services and extended post-delivery hospital stays. For these services, as for abortion, Medicaid applies specific necessity criteria or requires prior authorization.[117] Though the Alaska Supreme Court ruled in *Planned Parenthood 2001* that a woman who terminates a pregnancy and a woman who carries her pregnancy to term "must be granted access to state health care under the same terms as any similarly situated person,"[118] this ruling means that Medicaid must cover abortion and other pregnancy-related procedures equally to the extent they are medically necessary—not that abortion services and other pregnancy-related services are medically necessary in the exact same circumstances. Because abortion is one of a handful of procedures frequently sought even though not necessary to protect the patient's health,[119] it is legitimate for the State to apply special criteria to determine which ones are medically necessary for purposes of Medicaid coverage.

3. Mental illness v. physical illness

Under the statute's plain terms, coverage of abortion is authorized to avoid health risks posed by physical conditions. A mental health condition is grounds for coverage only if it poses a risk to the woman's life.[120] The limit on Medicaid funding for abortions sought for mental health reasons is substantially related to the purpose of the Medicaid

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117 7 AAC 110.280; 7 AAC 140.320(a).

118 28 P.3d at 913.

119 *See, e.g.*, Tr. 222, 276, 358, 360, 415, 419, 487, 489, 491-92, 490, 487.

120 AS 47.07.068(b)(4)'s definition of "serious risk to the life or physical health" includes risk of "impairment of a major bodily function" due to a list of specific physical conditions and a catch-all limited to physical conditions ("another physical disorder, physical injury, or physical illness . . ."), but it also includes risk of "death" which is not qualified by reference to physical conditions.

program because abortion is not officially recognized as treatment for any mental disorders. The superior court found that pregnancy can trigger expression of mental disorders, exacerbate their severity, or make treating mental illness more challenging. [Exc. 94-95, 97-98] But the evidence at trial showed that no published studies indicate that abortion is effective as *treatment* for mental disorders triggered or exacerbated by pregnancy, nor that it is endorsed as such by professional medical societies. [121] [Tr, 795-96, 804] Planned Parenthood's own witnesses conceded as much. Dr. Bibeault, a perinatal psychiatrist, was not aware of any studies that identify abortion as a treatment for perinatal mental illness. [Tr. 220-21] Dr. Meltzer-Brody, also a perinatal psychiatrist, was not aware of any such studies either, nor has she discussed abortion as a treatment in her own published work on perinatal depression. [Tr. 280-81, 301] Although these doctors attributed the absence of these studies to politics and bias, [Tr. 220-21, 280-81] Dr. Meltzer-Brody also conceded that the medical profession does not view abortion as an approach to treating mental disorders: "I don't think abortion is ever discussed as a treatment in the same way we consider medication treatment or psychotherapies. ... 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 . . . ." [Tr. 301-02]

Because Drs. Bibeault and Meltzer-Brody recognized the lack of empirical evidence supporting their view that abortion is medically indicated for the treatment of

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[121] Although studies have been conducted comparing outcomes for mentally ill women who have abortions against mentally ill women who carry to term, none indicate that abortion decreases mental disorders more than childbirth does. [Tr. 795-96]

to be the cause of post-partum depression are set in motion by pregnancy, abortion reduces the likelihood of suffering depression after pregnancy has ended. [Tr. 300-01]

The superior court's findings about abortion and mental health are therefore beside the point. There is no disputing that in some of the individual cases described by Planned Parenthood's witnesses, abortion appeared to alleviate psychiatric symptoms associated with the pregnancy. Nor can it be said that the superior court clearly erred in finding that "abortion may ameliorate psychiatric symptoms" and that "abortion is medically indicated to avoid psychiatric symptoms experienced in a previous pregnancy," according to the superior court's definition of medically indicated: "a body of evidence"—in this case the physician's own selective experience—"suggests intervention will result in a better outcome." [Exc. 88, 97] Yet Medicaid can and does reasonably treat mental illness with only generally accepted, evidence-based approaches proven to remedy or alleviate the patient's condition.[123] This approach is reasonable not only from a financial standpoint, but also because a person whose mental illness is being "treated" with an abortion may be missing the treatment that is actually effective for her condition.[124] [Tr. 800]

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[123] *See* 7 AAC 135.010(d) (excluding from scope of behavioral health services experimental therapy, narcosynthesis, primal therapy, and other approaches).

[124] Testimony at the trial strongly supports this possibility. Planned Parenthood's witness Dr. Renee Bibeault—a perinatal psychiatrist—described the "very involved process" of determining how to treat a mental health condition. [Tr. 204] It requires "a long interview" of approximately 60-75 minutes, during which the provider assesses "various aspects of the patient, such as their cognition, their mood, their speech, their thought process." [Tr. 234] Planned Parenthood witness Samantha Meltzer-Brody—a psychiatrist who specializes in women's reproductive mood disorders—agreed, describing a comprehensive evaluation. [Tr. 258] In contrast, Planned Parenthood doctor Dr. Lantzman spends between two and ten minutes, on average, talking to a woman to determine whether her abortion is medically necessary. [Tr. 422]

Even though abortion is not an officially recognized approach to treating mental disorders, the superior court concluded that the statute's exclusion of mental health conditions was inconsistent with what the court perceived as the program's coverage of treatments and procedures that would alleviate emotional distress in other contexts. [Exc. 115-117] Indeed, the superior court appeared to believe it is not possible or legitimate to draw a line between mental illness and lesser forms of mental or emotional distress, finding that there is no "recognized articulable standard to distinguish psychiatrically significant mental distress from normal sadness" and that "the determination is made experientially by a treater." [Exc. 94] Although true that a determination of whether a person suffers from psychiatrically significant mental distress is "made experientially by a treater"—as is any individual diagnosis related to physical or mental health—that does not mean that no articulable standards can guide medical professionals in diagnosis. Dr. Bibeault acknowledged referring to the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-V) when she is "undecided about a patient's diagnosis and . . . want[s] to refresh [her] memory about certain criteria." [Tr. 195] And although a bright line may not separate clinically significant distress from normal sadness, a reasonably clear line divides a woman merely experiencing distress from one suffering from a mental disorder according to the guidelines of the DSM-V. [Exc. 105] The standard of suffering from a "serious mental illness" or an "emotional disturbance" is

precisely how Medicaid determines coverage for behavioral health treatment.[125] And as explained above, it is reasonable for a government insurance program to cover proven treatments for mental disorders while not covering treatments to alleviate distress that does not rise to that level.

The superior court also found that substance abuse disorder is a recognized category of mental illness and that dual diagnosis of substance abuse plus a psychiatric disorder presents grave challenges. [Exc. 98] But as with other mental disorders, no studies or statements of professional organizations indicate that abortion is an acceptable approach to treating substance abuse in pregnant women. The superior court reasoned that the statute's denial of abortion coverage to a parent unable to overcome her addiction to drugs or alcohol is "at odds with[] the more universal tendency of Medicaid to assuage dire medical outcomes." [Exc. 114] This euphemistic phrasing cannot disguise the fact that abortion in this instance will not reduce any health risk to the mother (or the fetus); it will only prevent the birth of a child who might be born with a condition like fetal alcohol spectrum disorder. Terminating a pregnancy on the basis of this sort of value judgment does not fall within Medicaid's purpose of protecting its beneficiaries' health.

The same is true for abortions sought by pregnant women treating a mental disorder with psychotropic medications. Some psychotropic medications are teratogenic, creating a risk of birth defects (although the absolute risk of using most of these drugs

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[125] 7 AAC 135.020(a). An emotional disturbance is defined as a "non-persistent mental, emotional, or behavioral disorder ... identified and diagnosed during a professional behavioral health assessment." 7 AAC 135.990(d).

during pregnancy is relatively low).[126] But terminating the pregnancy in this situation does not protect the woman's health. Termination protects only against having a pregnancy with an elevated risk of fetal abnormality—by getting rid of the pregnancy entirely. [Tr. 811] Although terminating a pregnancy because of the risk that the child might be born with a physical or intellectual disability may relieve the pregnant woman's distress at having such a child, it is not "reasonably necessary for the diagnosis and treatment of an illness or injury, or for the correction of an organic system."[127] [Tr. 811]

Terminating a pregnancy due to fetal anomaly—whether due to psychotropic medication, substance abuse, or other causes—reflects moral and social considerations far beyond the Medicaid program's concern with protecting its beneficiaries' health. The Legislature's decision not to provide funding to "resolve" fetal anomalies (as the superior

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126 The most commonly prescribed psychotropic medications, anti-depressants, are considered safe to use in pregnancy. [Tr. 805, 813] Medications prescribed for the treatment of manic depression and bi-polar disorder elevate the risk of certain fetal anomalies. Depakote has been shown to increase the absolute risk of spina bifida to 0.6%. [Tr. 806] It is also associated with an increased rate of autism spectrum disorders—4.5% with babies exposed to Depakote, as opposed to 2.9% in the general population. [Tr. 808] The risk of Depakote having any effect on the baby is roughly 10%. [Tr. 816] Lithium is associated with a 0.8% risk of cardiac anomaly. [Tr. 806] Recent studies have downgraded the risk associated with taking Lithium during pregnancy. [Tr. 268]

127 7 AAC 105.110(1).

court put it) reflects a legitimate policy choice about the value of those with different physical and cognitive abilities and does not strip the law of a plainly legitimate sweep.[128]

In short, no peer-reviewed evidence or publications by professional organizations suggest that abortion will treat or alleviate mental disorders in pregnant women. Medicaid can reasonably decline to cover a procedure when there is no solid evidence showing that it is an effective treatment for the patient's condition. And while it is not surprising that having an abortion may alleviate distress caused by an unplanned pregnancy, Medicaid is not a program that provides all care that would alleviate beneficiaries' distress. Excluding abortions sought for mental health reasons from coverage—except when suicidal ideation poses a threat to the pregnant woman's life—is substantially related to legislative policy decisions drawing a line between protecting beneficiaries' health and optimizing their physical or emotional wellbeing.

For all these reasons, the Court should rule that AS 47.07.068 does not violate Alaska's equal protection clause. But if the Court concludes that the statute's limited coverage for mental health conditions violates the equal protection clause, it should uphold the regulation, with its broader provision for mental health conditions, instead.

D. The coverage limitations satisfy strict scrutiny.

Even if strict scrutiny applied to AS 47.07.068, the statute would not violate equal protection. To satisfy strict scrutiny, the government must establish that the challenged

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[128] Abortions for lethal fetal anomalies do not appear to be covered by the law—although the sponsors thought they were [*see* Exc. 133]—but, to the extent that the constitution requires funding in such a case, it could be determined on an as-applied basis.

law is justified by a compelling governmental interest.[129] The State also must show that no less restrictive means could advance that interest.[130]

The State has a compelling interest in protecting the health of its low-income citizens, who cannot afford needed health care without government assistance. The Medicaid program serves this compelling interest. Yet the feasibility of a program like Medicaid depends on the ability to set limits. The State could not afford, nor would the public tolerate, a Medicaid program that paid for any medical service or treatment a Medicaid beneficiary wants. Thus the State's compelling interest in protecting poor Alaskans' health through the Medicaid program is inextricably intertwined with a compelling interest in limiting the scope of Medicaid to care that is needed to "treat[] . . . an illness or injury" or provide assistance with a disability—not funding all care that would improve a patient's physical or emotional well-being.

Alaska Statute 47.07.068 is narrowly tailored to serve that compelling interest. The State has been fully reimbursing all abortions for Medicaid-eligible women. [*See* Tr. 150] Planned Parenthood's doctors have indicated that in their view an abortion is medically necessary whenever a woman wants one, and the judicially imposed definition of medical necessity for abortions endorses this practice. [Tr. 422, 460, 481, 522] In no other context does a patient's distress at her condition qualify a patient to receive Medicaid coverage. Instead, necessity is determined by objective medical criteria, even in the realm of mental

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129 *Ravin v. State*, 537 P.2d 494, 497 (Alaska 1975).

130 *Planned Parenthood 2001*, 28 P.3d at 909 (citing *Valley Hosp. Ass'n, Inc.*, 948 P.2d at 969).

health.[131] But if coverage for abortion must, as a constitutional matter, be determined by the patient's subjective sense of distress about being pregnant, then it is difficult to see how Medicaid can continue to maintain objective standards for coverage of other types of care.[132] In other words, Medicaid could be required to fund all kinds of services—individual therapy, weight-loss surgery, personal assistant care, infertility treatment—on the basis of patients' subjective feelings about their conditions. That sort of standard-less coverage could jeopardize Medicaid's viability. For this reason, AS 47.07.068's objective standard for medical necessity is narrowly tailored to further the State's compelling interest in limiting the scope of Medicaid to objectively necessary health care.

CONCLUSION

For these reasons, the Court should reverse the superior court's judgment ruling AS 47.07.068 unconstitutional and vacate its injunction. If the Court decides to uphold the superior court's judgment as to AS 47.07.068, it should reverse the judgment and vacate the injunction as to 7 AAC 160.900(d)(30).

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131 7 AAC 135.020(a), (b); 7 AAC 135.990(3).

132 *See* discussion *supra* at 38-39.