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

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

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

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

III. APPLICABLE LAW

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

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

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

IV. DISCUSSION

a) Statutory Construction.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[31] State Final Argument, February 25, 2015 at 11:51:40 AM.

[32] *State, Dept. of Health & Social Services v. Planned Parenthood of Alaska, Inc., supra* note 1 at 909.

[33] *State, DHSS*, 28 P.3d at 912 ("DHSS's differential treatment of Medicaid-eligible Alaskans

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[42] *Harris v. McRae*, 448 U.S. 297 (1980).

[43] *Moe v. Sec'y of Admin. & Finance*, 417 N.E.2d 387, 399-400 (Mass. 1981) (internal citations omitted).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. ORDER

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

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

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

John Suddock
Superior Court Judge

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

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

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