IN THE SUPREME COURT OF THE STATE OF ALASKA

STATE OF ALASKA, et al., Appellants, v. PLANNED PARENTHOOD OF THE GREAT NORTHWEST, HAWAI'I, ALASKA, INDIANA, and KENTUCKY, a Washington corporation, Appellee.	)	Supreme Court No.: S-19277

Trial Court Case No.: 3AN-19-11710 CI

APPEAL FROM THE SUPERIOR COURT
THIRD JUDICIAL DISTRICT AT ANCHORAGE
THE HONORABLE JOSIE GARTON, JUDGE

BRIEF OF APPELLANTS STATE OF ALASKA, ET AL.

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Constitutional provisions:

Art. 1, § 1. Inherent Rights

This constitution is dedicated to the principles that all persons have a natural right to life, liberty, the pursuit of happiness, and the enjoyment of the rewards of their own industry; that all persons are equal and entitled to equal rights, opportunities, and protection under the law; and that all persons have corresponding obligations to the people and to the State.

Art. 1, § 22. Right of Privacy

The right of the people to privacy is recognized and shall not be infringed. The legislature shall implement this section.

Alaska Statutes:

AS 18.16.010. Abortions

(a) An abortion may not be performed in this state unless

(1) the abortion is performed by a physician licensed by the State Medical Board under AS 08.64.200;

* * *

(c) A person who knowingly violates a provision of this section, upon conviction, is punishable by a fine of not more than $1,000, or by imprisonment for not more than five years, or by both.

* * *

AS 08.64.105. Regulation of abortion procedures

The board shall adopt regulations necessary to carry into effect the provisions of AS 18.16.010 and shall define ethical, unprofessional, or dishonorable conduct as related to abortions, set standards of professional competency in the performance of abortions, and establish procedures and set standards for facilities, equipment, and care of patients in the performance of an abortion.

PARTIES

The State of Alaska and the members of the Medical and Nursing Boards are the appellants. Planned Parenthood of the Great Northwest, Hawai'i, Alaska, Indiana, and Kentucky is the appellee.

ISSUES PRESENTED

Planned Parenthood challenges the constitutionality of AS 18.16.010(a)(1), which prohibits anyone other than a state-licensed doctor from administering an abortion.

1. *Privacy:* Does the law violate pregnant women's fundamental right to determine whether and when to have children?
2. *Equal Protection.* Does the law violate the equal protection rights of patients or advanced practice clinicians by authorizing only doctors, and not also advanced practice clinicians, to perform abortions?

INTRODUCTION

The Alaska Constitution protects a woman's fundamental right to determine "whether and when to have children."[1] But not every law touching on abortion is subject to strict scrutiny. For strict scrutiny to apply, the law must "significant[ly]" "tend[] to deter exercise" of that fundamental right.[2] Alaska's law authorizing only physicians to perform abortions does not do that. Although the law has been in place for half a century,

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[1] *Valley Hosp. Ass'n v. Mat–Su Coalition for Choice,* 948 P.2d 963, 968 (Alaska 1997).

[2] *State, Dep't of Health & Soc. Servs. v. Planned Parenthood of Alaska, Inc.* (*Planned Parenthood 2001*), 28 P.3d 904, 909 (Alaska 2001).

Planned Parenthood could not muster any evidence that any specific person was ever unable to get an abortion because of the law. The State, by contrast, presented hard data demonstrating that the law does not reduce access to abortion. Planned Parenthood's unsubstantiated impression that the physician-only law creates a theoretical burden does not suffice to trigger strict scrutiny. And when the physician-only law is assessed using the appropriate level of non-strict scrutiny, it passes constitutional muster.

STATEMENT OF THE CASE

I. The Alaska Legislature legalized abortions by state-licensed doctors and directed the Medical Board to regulate their administration.

In the 1960s, a national movement to decriminalize abortion swept across the nation.[3] At the time, "criminalizing abortion sent the practice underground, which resulted in a high death toll."[4] Abortion law reform activists sought changes through legislative and judicial decisions.[5] And courts began striking down, in whole or in part, laws criminalizing abortion.[6] The Alaska Legislature took note.

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[3] Planned Parenthood, Historical Abortion Law Timeline: 1850 to Today, https://www.plannedparenthoodaction.org/issues/abortion/abortion-central-history-reproductive-health-care-america/historical-abortion-law-timeline-1850-today (last visited Feb. 26, 2025).

[4] *Id.*

[5] *Id.*; *see also Roe v. Wade*, 410 U.S. 113, 140 & n.37 (1973) (discussing the then-recent "trend toward liberalization of abortion statutes").

[6] *See Roe*, 410 U.S. at 140 n.37 (discussing "state and federal courts striking down [then] existing state laws [criminalizing abortion], in whole or in part.").

By 1970, the legislature was considering not if but how to reform former AS 11.15.060, the law that criminalized abortions in Alaska.[7] The legislature was aware that "[r]ecent opinions of several courts, including the United States Supreme Court, ha[d] raised serious doubts . . . that the [then] existing language of the abortion law could pass any constitutional test."[8] Plus, a superior court in 1961 had narrowly interpreted Alaska's abortion statute to prohibit the killing of only *quickened* unborn children (meaning that abortion was not prohibited until about four months gestation), and it was unclear how this Court would interpret the statute if the issue came before it.[9] The legislature was also aware that Alaska's youth overwhelmingly supported changing the law that criminalized abortions.[10]

But, just like today, Alaskans in 1970 maintained divisive views on the issue. Some legislators believed that abortion before a fetus is viable should be "a matter of personal belief" and the law should not "forc[e] all [people] to conform to one view under threat of imprisonment."[11] Others continued to promote "the possibility of life, in

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[7] AS 11.15.060 (1962); § 65-4-6 A.C.L.A. 1949.

[8] 1970 Sen. J. Supp. No. 10 (Mar. 25, 1970) (Minority Report on CSSB 527); *see also* 1970 House J. Supp. No. 12 (Apr. 9, 1970) (Judiciary Comm. Report on SB 527) (discussing the possibility that Alaska's then-current abortion law would be struck down as unconstitutional in light of recent California, D.C., and Wisconsin cases, in which case Alaska would have "no law" on abortion.).

[9] Inf. Att'y Gen. Op. to House Rep. John Sackett (Apr. 25, 1969) (citing jury instruction in *State v. Boswell*, 60-109 (Sup. Ct., 4th Jud. Dist. (1961)).

[10] *Id.*

[11] 1970 Sen. J. Supp., No. 10 (Mar. 25, 1970) (report by members of the S. Jud. Com. Voting "do pass" in support of SB 527).

whatever form it might exist" because of "genuine, haunting doubts about the critical issue of life" and the "unanswerable questions" about when life begins.[12] The then-Governor wrote that the "central issue [in an abortion reform bill] is the right to life," and the constitution protects life and liberty, which includes "the life of an unborn child."[13]

The legislature compromised and passed a law authorizing safe, but regulated, abortion care in Alaska.[14] The reform legalized abortions, but allowed only doctors to administer them.[15] And it maintained felony penalties for anyone other than a doctor performing an abortion.[16]

The legislature delegated regulatory authority over abortions to the Medical Board, directing it to "adopt regulations necessary to carry into effect the provisions of AS 18.16.010," including setting standards "of professional competency in the

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12 1970 Sen. J. Supp., No. 10 (Mar. 25, 1970) (Minority Report on CSSB 527).

13 1970 Sen. J. pp. 792-93 (Apr. 17, 1970) (letter from Gov. Keith Miller to Sen. Pres. Brad Phillips).

14 SLA 1970, ch. 103. As enacted, the section of the law legalizing abortion was part of the criminal code at AS 11.15.060 (1970). That section has since been moved to chapter 18, at AS 18.16.010. The section directing the State Medical Board to adopt regulations continues to be housed in Title 8, Chapter 64.

15 1970 Sen. J. Supp., No. 10 (Mar. 25, 1970) (Minority Report on CSSB 527) (recommending a "compromise proposal [that] would prohibit any person other than a doctor, as defined in AS 08.64.200, from performing an abortion."); 1970 House J. Supp. No. 12 (Apr. 9, 1970) (Judiciary Comm. Rep. on SB 527) (discussing that if the old law criminalizing abortion applied to only quickened fetuses, then anyone could abort an unquickened fetus, and this bill actually tightened up the law by limiting abortions of unquickened fetuses to being performed only by doctors).

16 AS 18.16.010(c) (making a knowing violation subject to maximum of five years imprisonment); *cf.* AS 12.55.125(e) (providing that a class C felony is generally subject to maximum of five years imprisonment).

performance of abortions," and establishing standards for "care of patients in the performance of an abortion."[17] The legislature also delegated to the Medical Board the policy determination of what constitutes "ethical" and "unprofessional" conduct as related to abortions.[18]

The Medical Board has adopted such standards.[19] Its regulations provide that abortions may be performed only if requested by the pregnant woman;[20] only if the patient provides written informed consent;[21] only after a *physician* examines the patient;[22] and only after a *physician* estimates the patient's gestation after reviewing her history, examination, and test results.[23] These regulations execute the legislature's directive that the Medical Board regulate the ethical and professional administration of abortions.

Two years after passage of the 1970 abortion law, the voters approved a constitutional amendment that explicitly added the right to privacy to the Alaska Constitution.[24] In 1997, this Court held that the amendment was written broadly enough to encompass reproductive rights.[25] Since then, this Court has repeatedly reaffirmed the

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17 AS 08.64.105.

18 *Id.*

19 *See* AAC Tit. 12 (Professional Regs.), Ch. 40 (State Medical Bd.), art. 2 (Abortions).

20 12 AAC 40.060.

21 12 AAC 40.070.

22 12 AAC 40.080.

23 12 AAC 40.090.

24 Alaska Const. art. I, § 22.

25 *Valley Hosp. Ass'n*, 948 P.2d at 968-69.

existence of a fundamental and constitutional right to choose "whether and when to have children."[26] At the same time, this Court has also recognized the State's competing "legitimate interest in protecting a fetus."[27] Alaska's abortion regulations seek to protect a pregnant woman's safety and balance her fundamental (but not absolute) right to choose with the compelling (but not always overriding) interest in protecting and respecting fetal human life.

II. The Medical and Nursing Boards regulate their respective professions.

When the legislature delegated rulemaking authority to the Medical Board, it did so with the background understanding that the Medical and Nursing Boards regulate the practice of medicine and nursing. Both boards predate the 1970 abortion law.[28] The Medical Board regulates and licenses the practice of medicine by physicians and physician assistants.[29] The Nursing Board does the same for nurses.[30] It is a misdemeanor

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[26] *E.g.*, *State v. Planned Parenthood of Alaska (Planned Parenthood II)*, 171 P.3d 577, 581 (Alaska 2007).

[27] *Planned Parenthood 2001*, 28 P.3d at 913 (striking down law refusing to fund medically necessary abortions because the recognized state interest does not outweigh the life and health of the pregnant woman).

[28] § 35-3-112, A.C.L.A. 1949 (Nurses' Examining Board); § 35-3-82, A.C.L.A. 1949 (Territorial Medical Board).

[29] AS 08.01.070 (administrative duties of boards, generally); AS 08.64.100 (Medical Board's general regulatory authority); AS 08.64.101 (Medical Board's duties); AS 08.64.107 (regulation of physician assistants).

[30] AS 08.01.070 (administrative duties of boards, generally); AS 08.68.100 (Nursing Board duties and powers).

to practice medicine or nursing without a valid state-issued license.[31]

This lawsuit's reference to "advanced practice clinicians" (APCs) includes both physician assistants, who are regulated by the Medical Board; and advanced practice registered nurses (APRNs), who are regulated by the Nursing Board.[32] The Medical Board may impose disciplinary sanctions on its licensees who do not comply with the Medical Board's statute, regulations, and orders.[33] For instance, the Medical Board could discipline a doctor for providing a patient with a medication abortion without first examining her and estimating her gestational age.[34] The Nursing Board may impose disciplinary sanctions on its licensees for "wilfully or repeatedly" violating a statute governing nurses or regulation adopted by the Nursing Board.[35] But the Nursing Board does not have any regulations regarding abortions,[36] because—until the superior court's decision in this case—only doctors could perform them.

The legislature defines the scope of practice for professionals licensed by the Medical and Nursing Boards. [Tr. 200-01] Consistent with their statutory authority, the Boards further refine the scope of practice in regulation. [Tr. 201] The Nursing Board has

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31 AS 08.64.360 (misdemeanor for practicing medicine without a license); AS 08.68.340 (misdemeanor for practicing nursing without a license).

32 AS 08.64.107; AS 08.68.100(a)(1)(A).

33 AS 08.64.326(a)(7) ("The board may impose a sanction if the board finds after a hearing that a licensee . . . failed to comply with this chapter, a regulation adopted under this chapter, or an order of the board").

34 AS 08.64.326(a)(7); 12 AAC 40.080 and 12 AAC.40.090.

35 AS 08.68.270(8).

36 Title 12, chapter 44 of the Alaska Admin. Code.

further developed the "scope of practice" for APRNs by reference to "scope of practice statements published by national professional nursing associations recognized by the board."[37] In general, nursing professionals are trusted to determine for themselves what is within their scope of practice (i.e., their competence). [Tr. 202-03, 217, 232, 355-56]. But when an APRN is unsure about this, they can seek guidance from the Board of Nursing to see if a given service or procedure is "permissible" or "within their scope." [Tr. 354] The Nursing Board has done that for aspiration procedures to treat miscarriages. [Tr. 354-55] For instance, Ms. Bender, a Planned Parenthood APRN, sought guidance about whether she could perform aspirations to treat miscarriages. [Tr. 354-55, 460-61] That was not in her scope of practice while she worked in Alaska. [Tr. 460-61]

III. Most states do not allow non-doctors to perform abortions.

Shortly after the State of Alaska reformed its abortion ban and delegated regulatory authority of abortions to the Medical Board, the United States issued *Roe v. Wade*.[38] That case discussed the interests at stake: a woman's "decision whether or not to terminate her pregnancy" and a State's "important interests in safeguarding health, in maintaining medical standards, and in protecting potential life."[39] To effectuate these interests, the Court concluded that states have authority to "proscribe any abortion by a person who is not a physician," and to define physician "to mean only a physician

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37 12 AAC 44.430.

38 410 U.S. 113 (1973), *overruled by Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022).

39 *Roe*, 410 U.S. at 153-54.

currently licensed by the State."[40] In 1997, the United States Supreme Court held that the federal constitution allowed a state law to require abortions to be done by licensed doctors, "*even if an objective assessment might suggest that those same tasks could be performed by others.*"[41] At that time, 40 other states had similar rules, allowing only doctors—and not other medical practitioners—to perform abortions.[42]

Since 1997, the practice of abortion has changed largely due to the introduction of mifepristone and misoprostol, a two-step oral medication that causes abortion. In 2000, the FDA approved the medication to terminate pregnancies up to seven weeks.[43] At that time, the FDA allowed only doctors to prescribe or supervise prescription of the drug.[44] [Tr. 253] In 2016, the FDA deemed the medication safe to terminate pregnancies up to 10 weeks and allowed other healthcare workers, such as nurse practitioners, to independently administer it.[45] [Tr. 253-54]

Despite these changes, most states still do not allow non-doctors to administer abortions, regardless of how they are performed. Fewer than half the states allow APCs to provide medication abortions. [Tr. 280] And even fewer states allow non-doctors to

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40 *Id.* at 165 (1973); *see also City of Akron v. Akron Ctr. For Reprod. Health, Inc.*, 462 U.S. 416, 447 (1983) (reiterating that there is "no doubt that, to ensure the safety of the abortion procedure, the States may mandate that only physicians perform abortions."); *see also Connecticut v. Menillo*, 423 U.S. 9, 11 (1975).

41 *Mazurek v. Armstrong*, 520 U.S. 968, 973-74 (1997) (emphasis original).

42 *Id.* at 969 & n.1.

43 *FDA v. All. for Hippocratic Medicine*, 602 U.S. 367, 375 (2024).

44 *Id.*

45 *Id.* at 375-76.

perform aspiration abortions. [Tr. 280] This was true even before the United States Supreme Court overturned *Roe v. Wade* in 2022.[46]

IV. Planned Parenthood provides reproductive care in Alaska and minimizes costs by using advanced practice clinicians rather than doctors.

Planned Parenthood provides reproductive health care and is the only publicly identified abortion provider in Alaska. [Tr. 41; Exc. 113] It operates clinics in Fairbanks and Anchorage (and until recently in Juneau[47]). [Tr. 41; Exc. 113]

Planned Parenthood offers two types of abortion methods: medication and procedural. [Exc. 114]

For a medication abortion, a patient generally takes two medications: first mifepristone, and then misoprostol within 48 hours later. [Tr. 251-52; Exc. 114] Planned Parenthood provides medication abortions through 11 weeks of gestation. [Tr. 43, 251, 304; Exc. 114] The major complication risks of medication abortion are low. [Exc. 115] The risk of excessive bleeding from a medication abortion increases further along in the pregnancy. [Tr. 305; Exc. 116]

Aspiration is one type of procedural abortion. [Exc. 115] For an aspiration abortion, a doctor dilates the cervix to access the uterus. [Tr. 257; Exc. 115] The doctor

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46 *Dobbs*, 597 U.S. 215 (overruling *Roe*); *see* Stip. of Facts in *Jenkins v. Almy*, 2:17-cv-366-NT, Dkt. 37 at p.8 ¶31 (citing 2018 data from Guttmacher Institute in case concerning constitutionality of Maine's law allowing only physicians to perform abortions).

47 Alaska Public Media, Juneau's Planned Parenthood Health Center is close permanently (Dec. 16, 2024), available at https://alaskapublic.org/news/health/2024-12-16/juneaus-planned-parenthood-health-center-is-closed-permanently.

then inserts a plastic tube into the uterus and suctions out the contents. [Tr. 257-58] Planned Parenthood provides aspiration abortions in Fairbanks and Juneau through 13 weeks and 6 days of gestation, or in Anchorage through 15 weeks. [Tr. 45, 303-04, 257]

After 15 weeks, a procedural abortion may be done by dilation and evacuation. [Tr. 257, 261, Exc. 115] This is similar to aspiration except that doctors use instruments in addition to suction to remove the fetal tissue. [Tr. 261; Exc. 115] Patients are eligible for dilation and evacuation abortions in Anchorage up to 17 weeks and 6 days. [303-04]

Medication and aspiration abortions are safer than carrying a pregnancy to term. [Tr. 269-70; Exc. 117] That said, abortion is not without risks or complications: the further along a patient is in her pregnancy, the "more complicated or risky" the aspiration or dilation and evacuation procedure becomes. [Tr. 46-47, 305] As the pregnancy progresses, the doctor must dilate the cervix further, using different instruments and medications to stretch open the cervix to accommodate a larger plastic tube to empty the contents of the uterus. [Tr. 258] For aspiration procedures, doctors also administer antibiotics, a local numbing medication, and sometimes intravenous sedation. [Tr. 259]

Abortions in the second trimester, after 14 weeks, involve procedures "that only [doctors] can provide," according to the head doctor of the Planned Parenthood affiliate for Viriginia. [Tr. 300] Doctors do not perform aspirations beyond 13 weeks, 6 days in Planned Parenthood's Fairbanks and Juneau offices, because Planned Parenthood does not have doctors outside of Anchorage with sufficient training to do higher gestational age aspirations. [Tr. 371] The medical director for Planned Parenthood in Alaska has said that there is no limit on gestational age for APCs performing abortions, but that abortions

after 14 weeks "would *likely* be offered by a physician" (i.e., not an APC) even if the law allowed APCs to perform them. [Tr. 371-72 (emphasis added)]

Some patients within 11 weeks of pregnancy, who are eligible for both medication and aspiration abortion, strongly prefer one method over the other. [Tr. 45, 256-57, 259-60; Exc. 116] Some patients are advised towards one method of abortion because of medical contraindications. [Tr 43-44, 254-55, 45, 259; Exc. 115-16]

The same medication and aspiration regimens used to induce abortions are also used to treat women experiencing early miscarriages. [Tr. 52-53, 263, 59-60, 261, 460; Exc. 117] APCs treat miscarriages with the same dosage of mifepristone and misoprostol that is used to cause abortions. [Tr. 59, 452; Exc. 117] The aspiration procedure can also be used to treat incomplete miscarriages, though this usually requires less cervical dilation. [Tr. 263, Exc. 117] Once aspirations are part of a practitioner's scope of practice, the practitioner must administer them often to maintain that procedure within their scope of practice. [Tr. 370]

APCs administer other types of gynecological and obstetrical care, such as intra-uterine device (IUD) insertion and removal, cancer screening, and prescription of medications. [Tr. 184, 455-56; Exc. 119, 121] When a Planned Parenthood APC feels that a particular type of medical situation is outside their scope of practice, they elevate the issue to a doctor. [Tr. 183, 202]

Planned Parenthood keeps costs down by employing full-time APCs and limiting the use of doctors, whom it pays per diem. [Tr. 48; Exc. 124-25] This model reduces

financial and administrative costs for Planned Parenthood. [Tr. 55-57, 211, 477; Exc. 124-25]

Planned Parenthood financially benefits from using doctors as infrequently as possible. [Tr. 55-56] Planned Parenthood's doctors are paid per diem whereas its APCs are generally salaried. [Tr. 48][48] Planned Parenthood charges patients the same amount for abortions, irrespective of who performs them—that is, Planned Parenthood does not pass on the cost savings of using APCs to patients or their insurers. [Tr. 111] And when Planned Parenthood's Alaska offices are profitable, it uses its monetary savings to benefit clinics in other states. [Tr. 111-12]

Planned Parenthood also benefits administratively from not having to use per diem doctors to provide abortions. [Tr. 56-57; Exc. 124-25] Per diem doctors have other jobs, making scheduling doctors at Planned Parenthood more complicated. [Tr. 57; Exc. 125]

There is no shortage of available doctors to provide abortions in Alaska. [Tr. 407] Planned Parenthood chooses not to hire more doctors, considering itself "fully staffed" with doctors in Alaska. [Tr. 390, 396, 397, 398, 402, 403, 405] It has over the past several years rejected numerous doctors who have applied to provide abortions at its clinics because hiring them would "significantly increase Planned Parenthood's expenses

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[48] Planned Parenthood's responses to discovery illustrate the differential in costs. Planned Parenthood pays its per diem doctors at least $900 per day, and more for additional procedures above a quota. [R. 2990] On a typical doctor-staffed clinic day in Anchorage in 2021, a doctor would administer four medication abortions or 20 aspirations—20 aspirations costing Planned Parenthood between $1,800 and $3,000 per day. [R. 3032; R. 2990] By contrast, its salaried APCs earn between $75,457 and $135,525 per year. [R. 2991]

and administrative burdens." [Exc. 125; Tr. 392-407] It has even turned down doctors who seek to work for Planned Parenthood on a volunteer basis, and has recommended doctors instead help clinics in the Lower 48. [Exc. 1-15; Tr. 395-96, 398, 406] Planned Parenthood often staffs doctors for half days only, because that is sufficient to meet the demand for abortion in Alaska. [Tr. 374; *see also* Tr. 650-51]

V. In 2019, Planned Parenthood sued to challenge the law prohibiting non-doctors from performing abortions, and got a preliminary injunction.

In 2019, Planned Parenthood sued the State of Alaska. [Exc. 31-67] It claimed that Alaska's law permitting only doctors to administer abortions is unconstitutional because it does not also permit APCs to administer abortions. [Exc. 65-66]

The complaint asserted two main constitutional theories: first, that precluding abortions by APCs violates its patients' rights to privacy and liberty without adequate justification, and second, that it violates patients' and APCs' rights to equal protection. [Exc. 32, 37, 65-66] The equal protection claim rested on two categories of unequal treatment. [Exc.37-38, 66] First, it asserted the law unlawfully treats women who want to end their pregnancies differently from those seeking other reproductive medical care, because it bars abortions by APCs while allowing other equally complex gynecological and obstetrical care by APCs. [Exc. 66] Second, it asserted that the law unjustifiably treats APCs differently from Alaska-licensed doctors. [Exc. 66]

In November 2021, the superior court entered an order preliminarily enjoining the State from enforcing its physician-only law against APCs providing medication abortions. [R. 991-1001] The preliminary injunction created a natural experiment as to

the actual effect of the physician-only law, because after its issuance, nearly all medication abortions at Planned Parenthood were done by APCs. [Exc. 122]

After a year and half under the preliminary injunction, the superior court denied the parties' cross motions for summary judgment. [Exc. 85-86] The superior court concluded that there was a material dispute about whether the physician-only law substantially burdened versus only minimally impacted the fundamental right to reproductive choice. [Exc. 99, 106] The court concluded that the disputed facts, when resolved, would determine which level of constitutional scrutiny to apply. [Exc. 96-106]

VI. After a week-long trial, the superior court permanently enjoined the law as unconstitutional as applied to properly trained advanced practice clinicians.

The superior court held a week-long bench trial in November 2023. [Tr. 1] Planned Parenthood presented testimony from numerous witnesses, and the parties presented exhibits about the steady rates of abortion in Alaska before and after the superior court's preliminary injunction as well as Planned Parenthood's strategic decisions to minimize use of doctors in its Alaska clinics. [Tr. 4-5; R. 2942-43]

The medical director for Planned Parenthood in Alaska, Dr. Pasternack, could not recollect any details of any scenario in which a patient could not get an abortion because of the physician-only law. [Tr. 150-51] She testified about the company's intentional lean staffing, administrative and financial interests in challenging the law, and medical standards for abortion. [Tr. 32-65, 413-40] She testified that she "realized [the physician-only law] was a burden" only *after* the national Planned Parenthood organization decided to file this lawsuit. [Tr. 97-99] When asked for an example of a woman that Planned

Parenthood could not accommodate because of the physician-only law, she could recall only two women who needed urgent abortions, and testified that Planned Parenthood was able to accommodate both of them. [Tr. 113-15] She could not articulate an approximate number of people who might have been unable to get an abortion because of the law. [Tr. 102; *see also* Tr. 440] She testified that in the infrequent event that a patient needs an urgent abortion, Planned Parenthood asks a local doctor to perform it or schedules the procedure on a non-procedure day. [Tr. 83-84, 114-15] And she testified that her private practice works similarly: when an established patient has an urgent gynecological matter, her clinic accommodates them. [Tr. 115] She indicated that before the injunction a "few patients" gestated past the cutoff date for a medication abortion before attending an abortion appointment, and she could think of one patient who similarly gestated past the medication cutoff after the court's preliminary injunction. [Tr. 94, 102-03]

The former lead clinician for Planned Parenthood in Alaska, Ms. Bender, testified about her work as an APC; her direct care to patients in Alaska, including miscarriage management and abortion services; and Planned Parenthood's incorporation of telehealth into its practice model to effectively and efficiently serve its patients. [Tr. 339-57, 441-535, 644-94] She testified that as soon as she began working for Planned Parenthood in Alaska in 2018, she "immediately" believed the physician-only law burdened patients. [Tr. 507-08] (Before 2018, she had worked for Planned Parenthood in Maryland, which had a similar law.[49] [R. 2703]) She testified that despite this belief, she never raised the

[49] Md. Code Ann., Health-Gen. § 20-208 (2018) ("An abortion must be performed by a licensed physician."). In 2022, Maryland amended the law to allow state-authorized

issue to Planned Parenthood leadership. [Tr. 508]

Ms. Bender's opinion that the physician-only law burdened patients seemed to be grounded in patients' "hard to quantify" but not "infrequent" need for successive appointments. [Tr. 481-87] She testified that sometimes a patient would need a successive appointment for an abortion—either because Planned Parenthood mis-scheduled her for an abortion appointment with a non-doctor or because she came in for a non-pregnancy matter, discovered she was pregnant, and decided she wanted an abortion. [Tr. 481-87] Sometimes, the patient made a successive same-day appointment. [Tr. 481, 529-32] Other times, the patient made a successive appointment for another day when a doctor was available. [Tr. 481-82] In a hard-to-interpret answer that the superior court called "highly speculative," Ms. Bender said she believed that "about 20 to 30 patients" "were impacted by" the physician-only law in that they ended up continuing their pregnancies (for whatever reason) instead of attending appointments. [Tr. 488; Exc. 124 n.30] And she testified that some patients came in for appointments past the deadlines for certain types of abortion care. [Tr. 487] Finally, she testified that having only a few available appointment days a month made scheduling more challenging in light of women's childcare, work, and privacy concerns. [Tr. 502]

Three other experts testified. The chief medical officer for Planned Parenthood in Virigina, Dr. Ramesh, testified as an expert in the norms and standards for providing gynecological and obstetrical service. [Tr. 237-337] Dr. Spetz, Ph.D, testified as an

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medical providers to administer abortions if within the individual's scope of license or certification. Md. Code Ann., Health-Gen. §§ 20-207, 20-208 (2022).

expert in national labor markets and the nursing workforce and health care delivery. [Tr. 172-235] And Dr. Johnson, Ph.D., testified as an expert in intimate partner violence and the barriers women experience in such situations throughout Alaska. [Tr. 562-640]

The parties also presented exhibits. The exhibits showed that after the court's preliminary injunction allowing APCs to administer medication abortions, (1) the total number of abortions did not rise, (2) the preexisting trend of women choosing medication over aspiration abortion continued, and (3) the wait time from when a patient scheduled an abortion until her appointment date increased. [Exc. 17-30 (full exhibits at R. 3040-3269)] Email exhibits also showed that Planned Parenthood in Alaska rejected several doctors who asked to work for them, even on a volunteer basis. [Exc. 1-15]

In its ruling after trial, the superior court acknowledged the evidence cutting against a finding that the physician-only law caused enough delay to deter access to abortion. [*See, e.g.*, Exc. 122, 124 & n.30, 129] For instance, the court concluded that evidence suggested that Planned Parenthood already had sufficient doctor capacity before the injunction to meet the demand for abortions in Alaska. [Exc. 122] The total number of abortions performed after the injunction—when APCs administered nearly all medication abortions—did not rise. [Exc. 122; *see also* Exc. 17-19, 28; Tr. 385-86] And Dr. Pasternek expressly confirmed that Planned Parenthood meets the needs of patients who show up to their appointments with Planned Parenthood. [Tr. 387-89, *see also* Tr. 110, 125]

The court acknowledged that, "in the vast majority of cases," Planned Parenthood overcomes the barrier the physician-only law creates. [Exc. 124] Indeed, Dr. Pasternek

confirmed this; when asked for a specific example when Planned Parenthood was unable to provide an urgent abortion, she provided only examples of when Planned Parenthood successfully provided urgent abortions. [Tr. 83-84, 113-15]

The court acknowledged that wait times actually *increased* after its injunction allowing APCs to provide abortions, which the court noted did "not support Planned Parenthood's assertion that AS 18.16.010(a)(1) acts as a barrier to patients seeking abortion." [Exc. 129; *see also* Exc. 20, 22 (R. 3165)] The court observed that the longer time between making and attending an abortion appointment may have reflected more choice in appointment times rather than the time of the next available appointment. [Exc. 126, 129] Dr. Ramesh and Ms. Bender's testimonies echoed this conclusion: the longer post-injunction wait times could be attributed to women choosing farther-out appointments that better met their schedules. [Tr. 335; Tr. 498-99, 522, 687-88]

The superior court found that Planned Parenthood offered "anecdotal" and "impressionistic" testimony that was at times "highly speculative" about women who were denied abortions or the types of abortions they preferred because of the physician-only law. [Exc. 122-24 & 124 n.30] Although the court found Dr. Pasternek and Ms. Bender "credible" generally in their knowledge that some of their patients experienced a delay in getting an abortion because of the physician-only law [Exc. 122-23], the court refused to credit Ms. Bender's more specific but "highly speculative" testimony that the delay actually deterred a number of women from accessing abortion or their choice of abortion method. [Exc. 124 n.30]

The superior court did not find that the rise of medication abortions (and decline of

aspiration abortions) was caused by its preliminary injunction. [Exc. 126] (During the preliminary injunction, medication abortions were offered three to six times a week as compared to one to two times a week before the injunction.) [Tr. 479-80, 653-58] The court acknowledged that the increasing number of medication abortions compared to aspiration abortions followed the nationwide trend and occurred during the same period that Planned Parenthood changed its protocols to eliminate or streamline follow-up requirements for medication abortion. [Exc. 126] Indeed, exhibits and testimony showed that the nationwide trend favoring medication abortions preceded the court's preliminary injunction and continued after the injunction was issued. [Tr. 145-46; Exc. 26-29 (exhibits graphing increased trajectory of medication abortions well over a year before the injunction)] Plus, in 2020, Planned Parenthood changed the gestational cutoff for medication abortions from 10 to 11 weeks. [Tr. 143-44] And in 2021, Planned Parenthood changed two policies to further reduce obstacles to medication abortions: (i) it no longer required in-person follow up care, and (ii) it no longer required patients to remain close to emergency departments for about a week after the appointment. [Tr. 136, 136-44, 469-70, 474-75] Dr. Pasternek testified that all these changes (which preceded the preliminary injunction) made medication abortions more available (and often preferable) as compared to aspiration abortions, especially to patients traveling from rural Alaska. [Tr. 138-46]

But then, after casting much of Planned Parenthood's testimony as "impressionistic," discrediting Planned Parenthood's "highly speculative" testimony, and acknowledging that the data did not support Planned Parenthood's theory of harm

[Exc. 122-24 & 124 n.30, 129], the court nonetheless found that the law deterred a non-zero number of people from exercising a fundamental right:

> As a result of AS 18.16.010(a)(1), some patients experience delays in obtaining abortions, some delays result in those patients no longer being eligible to obtain their preferred type of abortion, some patients are forced to travel greater distances to access abortion care, including out of state, and some patients do not receive abortion care even when they desired to terminate their pregnancy. [Exc. 130]

The court also made findings about patients' other barriers to care. It found that patients seeking abortion services face numerous obstacles related to work, school, childcare, and need to reschedule and travel to their appointments given these barriers. [Exc. 127] The court found that patients sometimes delay care because of their personal obligations. [Exc. 127] And the court found that delay, whatever the cause, can increase financial, physical, and psychological costs for patients. [Exc. 127-28] The court found that barring APCs from providing abortion creates a "potential for greater delay." [Exc. 129] And the court found that if medication and aspiration abortions are available every day Planned Parenthood's health centers are open, that can significantly reduce the impact of delay, even when patients need to reschedule for their own reasons. [Exc. 127]

Because of this perceived burden on a fundamental right, the court applied strict scrutiny. [Exc. 130] It concluded that the law was unconstitutional "as applied to APCs whose scope of practice includes medication or aspiration abortion." Exc. 133]

The court concluded that the physician-only law violated the constitutional right to privacy because it did not serve a compelling interest using the least restrictive means. [Exc. 130-31] It concluded that "prohibiting otherwise qualified APCs from performing

medication and aspiration abortion" did not advance the State's legitimate interest in the health and welfare of women seeking to terminate their pregnancies. [Exc. 130-31] It concluded that the law was not the least restrictive means to accomplish its goals because the Medical and Nursing Boards already comprehensively regulate the practice of medicine, and another law already criminalizes the practice of medicine by non-doctors and non-nurses. [Exc. 131-21]

The court concluded that the law violated equal protection as well. [Exc. 131-21] It concluded that pregnant women seeking medication and aspiration treatment for abortion are similarly situated to pregnant women seeking medication and aspiration treatment for miscarriage, who can be treated by APCs. [Exc. 131-21] And it concluded that treating these similarly situated women differently was unconstitutional. [Exc. 132] Finally, the court concluded that the State had no legitimate interest in treating APCs and doctors differently in this context, so the law also violated the APCs' right to equal protection too. [Exc. 133]

The superior court therefore permanently enjoined the State from enforcing AS 18.16.010(a)(1) against "otherwise qualified APCs whose scope of practice includes medication or aspiration abortion." [Exc. 134]

STANDARDS OF REVIEW

The Court independently reviews constitutional questions.[50] The Court reviews

[50] *Planned Parenthood II*, 171 P.3d at 581.

factual findings for clear error.[51] Evidentiary rulings are reviewed for abuse of discretion.[52] But when the admissibility of evidence turns on the "correct scope or interpretation of a rule of evidence," this Court applies its independent judgment.[53]

ARGUMENT

I. Because the physician-only law does not substantially impair abortion access, the superior court erred in applying strict scrutiny.

The level of scrutiny this Court applies when reviewing constitutional privacy and equal protection challenges depends not only on the type of right at issue but also on the degree to which the law impairs that right.[54] For a constitutional privacy claim to get off the ground, there must be "a claim of a substantial infringement, as distinguished from a minimal one."[55] Similarly, for equal protection, "if the burden placed on constitutional

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51 *Id.*

52 *Davison v. State*, 282 P.3d 1262, 1266-70 (Alaska 2012).

53 *Sanders v. State*, 364 P.3d 412, 420-22 (Alaska 2015).

54 *Alaska Pacific Assur. Co., v. Brown*, 687 P.2d 264, 272 (Alaska 1984) (for equal protection analysis, "[t]he parties' contentions regarding whether the right to travel is burdened by [the statute] and the extent of that burden are related both to the selection of the standard of review and the question of whether the statute is fairly designed to accomplish its purposes"); *Ranney v. Whitewater Eng'ring*, 122 P.3d 214, 222 (Alaska 2005) (assuming a fundamental right under the constitutional privacy clause, but finding no constitutional violation because the law "at most imposes only a minimal burden" and no "significant burden" on the asserted right); *Doe v. Dep't of Pub. Safety*, 444 P.3d 116, 126-27 (Alaska 2019) (under the privacy clause, the claim must be a "substantial infringement," rather than a "minimal one"); *Cf. Kohlhaas v. State*, 518 P.3d 1095, 1104, 1113 n.124 (Alaska 2022) (considering "the character and magnitude of the asserted injury" on the right to association).

55 *Doe v. Dep't of Pub. Safety*, 444 P.3d at 126-27; *Ranney*, 122 P.3d at 222 (assuming a fundamental right, but finding no constitutional violation because the law "at most imposes only a minimal burden" and no "significant burden" on the asserted right); *cf. Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 873 (1992) ("[N]ot every

rights by the regulation is minimal, then the State need only show that its objectives were legitimate for the regulation to survive an equal protection challenge."[56] By contrast, "if the objective degree to which the challenged legislation tends to deter exercise of constitutional rights is significant, the regulation cannot survive constitutional challenge unless it serves a compelling state interest."[57]

It is undisputed that the right at issue here—"the choice of whether and when to have children"[58]—is fundamental. But that does not mean strict scrutiny necessarily applies. Rather, strict scrutiny only applies if the physician-only law *substantially* impairs that fundamental right.[59] This Court looks to "the real-world effects of government action" to determine the appropriate level of scrutiny.[60] "The suspicion with which this court will view infringements upon constitutional rights depends upon the objective

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law which makes a right more difficult to exercise is *ipso facto*, an infringement of that right.").

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

57 *Id.* (cleaned up); *see also State v. Planned Parenthood of the Great Nw.* (*Planned Parenthood 2019)*, 436 P.3d 984, 1001-02 (Alaska 2019).

58 *Valley Hosp.*, 948 P.2d at 968; *see also Planned Parenthood II*, 171 P.3d at 581.

59 *Doe v. Dep't of Pub. Safety*, 444 P.3d 116, 126–27 (Alaska 2019) ("But the mere invocation of the right to privacy does not automatically trigger a strict scrutiny analysis. For the right to privacy to apply, there must be both a legitimate expectation of privacy and a claim of a substantial infringement, as distinguished from a minimal one."); *Planned Parenthood 2001*, 28 P.3d at 909; *cf. State v. Alaska Democratic Party*, 426 P.3d 901, 909 (Alaska 2018) ("The extent of the burden determines how closely we will scrutinize the State's justifications for the law: substantial burdens require compelling interests narrowly tailored to minimally infringe on the right; modest or minimal burdens require only that the law is reasonable, non-discriminatory, and advances "important regulatory interests.").

60 *Planned Parenthood 2001*, 28 P.3d at 910.

degree to which the challenged legislation tends to deter the exercise of those rights."[61] Here, strict scrutiny does not apply because the physician-only law does not actually deter the exercise of the right to choose whether and when to have children.

A. The post-injunction data shows that the physician-only law does not prevent women from accessing abortion care.

The superior court's preliminary injunction created a natural experiment that proved that the physician-only law does not prevent women from receiving abortions in Alaska. During the injunction—while APCs were permitted to administer medication abortions—the number of abortions did not rise. [Exc. 17-19, 122] Planned Parenthood's theory is that the physician-only law limits appointment availability and that limited appointment availability might cause enough delay to impede access to abortion. [Exc. 59, 61] But the data does not support this theory.

Nor did enjoining the law reduce delay. [Exc. 20, 21] The statistical evidence shows that once APCs began providing medication abortions, wait time between abortion scheduling and abortion appointments did not decrease—it actually increased. [Exc. 20-25] Planned Parenthood's witnesses testified that after the injunction women could (and did) select *later* dates to schedule abortions because they had more available dates to choose from. [Tr. 335 (Ramesh); *see also* Tr. 330-31 (Ramesh); Tr. 498-99 (Bender)] Dr. Ramesh opined that with more availability, patients are not limited to one or two available appointments each week and can instead "choose to wait" and take a later

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61 *Id.* (cleaned up).

appointment that better fits their schedule. [Tr. 335; *see also* 687-88 (Ms. Bender testifying to the same)] This evidence thus did not show that the physician-only law delayed access to abortion care—it showed the opposite. It showed that eliminating the physician-only requirement allowed patients more flexibility, with which patients themselves chose to delay their appointments.

The statistical uptick in medication abortions over the past few years does not indicate that the physician-only law impaired access to medication abortions. The superior court correctly refused to interpret the uptick as *caused* by the court's injunction allowing APCs to administer medication abortions. [Exc. 126-27] Rather, in accordance with Dr. Pasternak's testimony, the superior court recognized that the increase in medication abortions (as compared to other types of abortions) in Alaska followed a nationwide trend. [Exc. 126; Tr. 144-46 (testimony confirming trend); R. 3481-82 (graphic representation of trend)] Plus, Planned Parenthood changed its protocols to eliminate or streamline follow-up requirements for medication abortion, making them more popular. [Exc. 126; Tr. 137-43] And Planned Parenthood extended the gestational limit for medication abortions, making them available to women further along in their pregnancies. [Tr. 143-44]

Thus, the hard data introduced at trial showed that the physician-only law does not prevent women from accessing abortion care nor delay such care.

B. Planned Parenthood's vague, non-specific testimony does not show that the physician-only law tends to deter abortion access.

The physician-only law has been functioning for over a half century, during which time Planned Parenthood providers have administered tens of thousands of abortions. [R. 3480] Yet Planned Parenthood did not identify with any particularity a single woman who was unable to get an abortion at any point across these decades because of the physician-only law.

Regardless, the appropriate question is not whether the physician-only law ever deterred access to a single abortion or a type of abortion. [*See* Exc. 126-27] The relevant question is whether the law "tends to deter the exercise" of abortion in the post-2021 world given Planned Parenthood's use of telemedicine and its 11-week gestational cutoff for medication abortions.[62] The evidence does not support such a finding.

Dr. Pasternek testified that she could remember two patients who needed urgent abortions, and Planned Parenthood accommodated them both. [Tr. 114-15] She testified that Planned Parenthood reaches out to local doctors to accommodate time-sensitive abortion care. [Tr. 83-84] Although she testified that Planned Parenthood was only "sometimes" able to accommodate women with urgent abortion needs, when asked for an example of when Planned Parenthood was unable to do so, she could not provide one. [Tr. 113-15] Moreover, the urgent abortion requests she could recall were not made urgent *because of the physician-only law.* [Tr. 114-15]

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62 *Planned Parenthood 2001*, 28 P.3d at 910.

Dr. Pasternek opined that the physician-only law created a "small burden" on a "few patients" (though she could not say how many). [Tr. 103] But a "small burden" is not substantial enough to trigger strict scrutiny.[63] While the superior court found that the law caused some patients to need successive appointments, which caused some delay [Exc. 123], that does not mean the delay impaired their fundamental right. The delay for such people is, as Dr. Pasternek testified, a "small burden." [Tr. 103]

Ms. Bender testified that women sometimes had to return to Planned Parenthood for a second appointment if Planned Parenthood mis-scheduled an abortion appointment on a day a doctor was unavailable or if a patient came in for a non-abortion appointment, found out she was pregnant, and wanted an abortion. [Tr. 481] But that does not mean that patients were deterred from accessing abortion care. The superior court found "highly speculative" (and thus not credible) Ms. Bender's estimation that the need for a second appointment caused "about 20 to 30 patients" to continue their pregnancies. [Exc. 124 n.30; Tr. 488] Not only did the court discredit Ms. Bender's estimation, but Ms. Bender's anecdotal testimony about patients who needed a successive appointment includes women who, upon discovering they were pregnant, wanted a moment to think about their decision and would have needed a second appointment notwithstanding the

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63 *See Doe v. Dep't of Pub. Safety*, 444 P.3d at 126-27 (laying out the distinction between substantial and minimal burdens for privacy claims); *Ranney*, 122 P.3d at 222 (holding that a privacy claim failed because the burden was minimal); *Planned Parenthood 2001*, 28 P.3d at 909 (discussing the sliding scale framework for constitutional rights depending on the degree of burden).

physician-only law. [Tr. 486] And Ms. Bender's vague testimony alluding to women who continued their pregnancies did not articulate *why* they continued their pregnancies:

> I mean, some of those patients I saw for visits after the fact that they came out, some of which I saw medical record requests come in, you know, that I saw that they had continued their pregnancy. Some of those patients came back to see us during their pregnancy for other things. And they shared that, you know, with us, unprovoked. [Tr. 488]

What did these women share unprovoked? That they did not decide whether to get an abortion until it was too late? That they changed their mind about getting an abortion? That they did not get an abortion because they could not line up childcare for an appointment? This non-specific, vague testimony does not show that the physician-only law substantially burdens abortion access.

The physician-only law merely requires a physician to administer an abortion.[64] Planned Parenthood offers physician appointments one to two times a week, has sufficient physician availability, and aims to accommodate patients near gestational cutoffs for medication, aspiration, or dilation and evacuation abortions. [Tr. 83-84, 110, 114-15, 125, 387-89, 653-58, 668-69] The superior court also recognized that notwithstanding the physician-only law, "Planned Parenthood has been able to meet the overall demand for abortion care" in Alaska. [Exc. 122] Indeed, Planned Parenthood has repeatedly turned away doctors who could provide more abortion care. [Exc. 1-15]

The fact that the law affects a very small number of women also cuts against applying strict scrutiny. In the different fundamental rights context of voting, this Court

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64 AS 18.16.010(a)(1).

has recognized that election laws "will invariably impose some burden upon individual voters," but that does not mean every voting regulation is subject to strict scrutiny because such a rule "would tie the hands of States seeking to assure that elections are operated equitably and efficiently."[65] The same rationale applies to laws about medical care—if strict scrutiny automatically applies to every law touching on bodily autonomy and medical choice, the Court would have to assess whether every medical regulation is the least restrictive means of furthering compelling state interests, putting the Court in the position of second-guessing regulatory line-drawing on every technical question.[66]

The Court's framework for facial challenges also informs this appeal. When assessing whether an abortion law is facially constitutional, the Court upholds the constitutionality of the law "even if it might occasionally create constitutional problems in its application."[67] Here, Planned Parenthood asserts that it brings an "as-applied"

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65 *O'Callaghan v. State*, 914 P.2d 1250, 1253-54 (Alaska 1996).

66 For example, the FDA approves medication abortions up to ten weeks' gestation and Planned Parenthood administers that medication up to 11 weeks' gestation. If the State were to authorize use only until 10 weeks and six days gestation, and if strict scrutiny applied to that regulation, then this Court would have to determine whether ten week and six days was the least restrictive alternative or whether 11 weeks is, or maybe 11 weeks and one day. Strict scrutiny in such a situation would hamstring the Medical and Nursing Boards' decision-making and it would interfere with deference owed to highly-technical regulatory bodies.

67 *Planned Parenthood 2019*, 436 P.3d at 1000; *see also Planned Parenthood of The Great Nw. v. State (Planned Parenthood III)*, 375 P.3d 1122, 1133 (Alaska 2016); *Planned Parenthood II*, 171 P.3d at 581. The Court uses this standard in the context of First Amendment and abortion cases, whereas it upholds the facial constitutionality of statutes in other contexts so long there is a "set of circumstances under which the statute can be applied consistent with the requirements of the constitution." *Ass'n of Vill. Council Presidents Reg'l Hous. Auth. v. Mael*, 507 P.3d 963, 982 (Alaska 2022) (applying the *Salerno* framework).

challenge: it argues that the physician-only law is unconstitutional "as applied to APCs who perform medication abortion and aspiration." [Exc. 66] But this is not like the typical as-applied challenge in which a plaintiff alleges that a law, *as applied to the plaintiff's personal situation*, violates the plaintiff's fundamental rights.[68] Instead, Planned Parenthood's challenge is more similar to a facial attack arguing that the law is unconstitutional as applied to APCs because it deters abortion in a sufficient number of situations.[69] That type of broad, general challenge to a law is normally evaluated subject to the Court's admonition that it will uphold a law if it has a "plainly legitimate sweep."[70]

The Court should not strike down a law in broad, general terms based on the specific circumstances of a small subset of imagined, but absent, hypothetical plaintiffs. What if just one woman did not receive an abortion because APCs cannot legally perform them? Would that be enough to hold the law unconstitutional as applied to all abortions for all women (just because the ruling would be, in a sense, only "as applied" to APCs)? The superior court concluded that it could not quantify the number of times the physician-only law creates a substantial burden, but it was likely very low. [Exc. 122, 124] The State challenges this finding, but even if it were correct, that does not make the law *always* unconstitutional as applied to APCs. It would mean, rather, that the law

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68 *See, e.g.*, *Barber v. State, Dep't of Corr.*, 314 P.3d 58, 63-66 (Alaska 2013) (applying heightened scrutiny to an as-applied challenge of a court filing fee because it inhibited an indigent prisoner from accessing the court to adjudicate his liberty claim).

69 *Planned Parenthood II*, 171 P.3d at 581, 583-84 (facial challenge against statute that shifts a minor's decision-making on whether to abort a child to her parents and increases the probability that the minor may not receive a safe and legal abortion).

70 *Planned Parenthood 2019*, 436 P.3d at 1000.

"occasionally create[s] constitutional problems" in a *subset* of applications to APCs.[71] And this Court upholds the constitutionality of laws despite "occasional[ ] constitutional problems" in application.[72]

C. Barriers and circumstances unrelated to the physician-only law do not show that the law substantially burdens abortion access.

The superior court appeared to conclude that *any* burden on abortion care is subject to strict scrutiny given that some patients face other barriers, such as socioeconomic hardship. [Exc. 129] But that contravenes this Court's instruction that for strict scrutiny to apply, the law in question must *significantly* impair a fundamental right.[73] If even a slight effect on the right becomes "significant" just by adding in the possibility of unrelated patient life difficulties, any law whatsoever touching on abortion would be automatically subject to strict scrutiny.

Planned Parenthood failed to prove that *the challenged law*, rather than patients' other life circumstances, substantially burdened access to abortion care. Planned Parenthood provided evidence that many women experience barriers to abortion care unrelated to the physician-only law: some women have to reschedule appointments for multiple reasons, such as not being sure of their decision, work and childcare conflicts, and weather and transportation issues. [Tr. 485-86] Other women are in abusive relationships and are being monitored. [Tr. 580] But Dr. Pasternek's and Ms. Bender's

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71 *See Planned Parenthood III*, 375 P.3d at 1133.

72 *Planned Parenthood 2019*, 436 P.3d at 1000.

73 *Planned Parenthood 2001*, 28 P.3d at 909; *Doe v. Dep't of Pub. Safety*, 444 P.3d at 126-27.

testimony did not disentangle these unrelated barriers from a slight delay to a small number of patients caused by the physician-only law. [*See, e.g.*, Tr. 94 (discussing women who missed gestational cutoffs both before and after the preliminary injunction)] And the State could not disentangle the two through cross-examination because information about barriers of care was presented through layers of hearsay.

Relatedly, that hearsay was improperly admitted, and the superior court erred in its final decision by relying on such improper hearsay as the foundation for its analysis. [Exc. 123-24] Before trial, and over the State's arguments to the contrary, the superior court ruled that hearsay about patient delays was admissible because "[d]elays in scheduling, and the reasons for it," are relevant to a patients' treatment options, and statements "reasonably pertinent to . . . treatment" are admissible under Evidence Rule 803(4). [Exc. 101; R. 2001-04 (State Reply to MSJ); R. 689-92 (State Opp. to PP's MSJ)] The State explained again at trial why presenting this anecdotal evidence through a provider was hearsay: the hearsay did not fall into the exception for medical treatment, bore no indicia of reliability, and prevented the State from cross-examining the declarants. [Tr. 678-80] Certainly, the gestational age of a patient's pregnancy is relevant to the treatment options. But *why* a patient comes to Planned Parenthood at a particular gestational age rather than another is irrelevant to treatment. Indeed, Planned Parenthood does not record in medical records any conversations about delay and the reason for delay precisely because it is not relevant to medical treatment. [Tr. 98-102] And in its final order, the superior court even found that why a patient did not come to a clinic sooner

was "not relevant" to treatment. [Exc. 123] Such hearsay should not have been admitted, and it confused the reasons for delayed abortion care.

The superior court also erred in applying strict scrutiny on the basis that delays could increase financial, emotional, psychological, and physical costs on a patient. [Exc. 123, 128] Collateral consequences that do not tend to deter exercise of a fundamental right do not implicate strict scrutiny. For instance, if a patient had to return for a successive appointment because she came to Planned Parenthood to see a nurse, discovered she was pregnant, decided she wanted a medication abortion that same day, and a physician was unavailable; she might have to take more time off work or pay for more childcare, which would create a financial burden. [Tr. 664-65] But unless these "incidental costs," as Planned Parenthood calls them [Tr. 665], prevented her from getting an abortion, the physician-only law did not deter her access to her fundamental right. And Planned Parenthood did not present credible evidence proving that such collateral burdens tended to deter women from getting abortions. [*Compare* Exc. 124 n.30 (trial court's finding "highly speculative" (and thus not credible) Ms. Bender's testimony that the law deterred 20-30 women from getting an abortion, *with* Tr. 96 (explaining how Medicaid reimburses travel expenses associated with abortion care)] This Court applies rational basis review to economic interests.[74]

[74] *Mael*, 507 P.3d at 981 (applying rational basis review to law that restricts recovery of damages because it impairs only economic interest).

Or, by way of another example, if (as sometimes occurred) Planned Parenthood mis-scheduled an abortion appointment on a day when no doctor was available, a patient might have to return later, in the meantime suffering continued nausea and vomiting associated with pregnancy, which can be extreme for women with the rare condition of hyperemesis gravidarum. While these are real physical harms, they do not deter access to abortion. Planned Parenthood did not show, for instance, that having to wait one or two extra days to get an abortion meant that the woman suffering from hyperemesis was deterred from exercising her right to reproductive choice.

Likewise, Planned Parenthood did not show that non-delay related consequences of the law deterred access to abortion. For instance, Ms. Bender testified that some of her patients asked if she, rather than a doctor, could perform their abortion. [Tr. 660] But she also testified that no patient refused to have an abortion just because Ms. Bender, an APC, could not perform it. [Tr. 660; *see also* Tr. 367] By way of another example, Ms. Bender testified that if a patient had more flexibility in getting a medication abortion, that patient might be able to better keep their abortion private by trying to target the days the most bleeding occurs. [Tr. 693] But Planned Parenthood never provided evidence that not being able to decide the precise day to start a medication abortion ever deterred a patient from accessing abortion.

Planned Parenthood's own administrative and financial choices do not trigger strict scrutiny of the physician-only law either. Planned Parenthood chooses to not offer abortions every day its clinics are open, which the superior court found "can make it more difficult for patients to access care." [Exc. 127] But the physician-only law has

never prevented Planned Parenthood from offering abortion appointments every day of the week. Rather, prior to the injunction, Planned Parenthood *chose* to limit statewide abortion access to one to two times per week for its own administrative and financial benefit. [Exc. 125; Tr. 55-59, 109, 122-23, 645-46] It rejected additional doctors who wanted to work for the organization in Alaska—even on a volunteer basis—considering itself "fully staffed." [Exc. 1-15; Tr. 390-98] And Planned Parenthood uses the money it saves by administering care more cheaply in Alaska to benefit its other operations in other states.[75] [Tr. 111-12]

In short, strict scrutiny is only appropriate if the physician-only law (rather that other barriers and circumstances) substantially burdens access to abortion, and Planned Parenthood did not show that the law does so.

D. Strict scrutiny applies to an abortion law only when it tends to deter access to the fundamental right to reproductive choice.

This Court has never held that strict scrutiny applies to an abortion law that does not actually deter access to abortion. In every prior case applying strict scrutiny, such deterrence was obvious or undisputed. In *Valley Hospital*, the Court applied strict scrutiny to a policy that prohibited most abortions in the only hospital in the Mat-Su Valley.[76] Likewise in the parental involvement cases, the parties did not dispute the laws'

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[75] Planned Parenthood also diverts significant resources towards litigation and advocacy. This Court can take judicial notice of Planned Parenthood's numerous court cases across the country.

[76] *Valley Hosp. Ass'n*, 948 P.2d at 965 (evaluating a policy prohibiting abortions at the only hospital in the Mat-Su unless the fetus is incompatible with life, the mother's life is threatened, or the pregnancy was the result of rape or incest).

deterrent effect or the propriety of strict scrutiny. The Court concluded that the parental consent law "effectively shift[ed]" a pregnant minor's reproductive choice to that minor's parents.[77] And the State did not dispute the superior court's finding that the law would increase the probability that minors would not be able to receive safe and legal abortions.[78] The Court applied strict scrutiny to the parental notification law too because it created "impediments *preventing* minors from exercising their constitutional rights."[79] Deterrence was also undisputed in the Medicaid payment cases. In the 2001 case, the State admitted that the challenged regulation "would cause about thirty-five percent of women who would otherwise have obtained abortions to instead carry their pregnancies to term, despite the associated threat to their health."[80] And in the 2019 case, this Court concluded that the State's denying Medicaid payment for abortions deterred the exercise of reproductive freedom because the "biological reality requires that a woman who cannot afford a medical abortion must carry her pregnancy to term."[81]

This case is unlike all these cases in which the challenged laws actually and substantially infringed women's reproductive choice. The Court applies strict scrutiny based on "the objective degree to which the challenged legislation tends to deter exercise

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77 *Planned Parenthood II*, 171 P.3d at 583.

78 *Id.* at 584.

79 *Planned Parenthood III*, 375 P.3d at 1143 (emphasis added). The State argued in that appeal that the parental notice law passed strict scrutiny. *Appellee State of Alaska's Brief*, 2013 WL 4717804, *7, 11.

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

81 *Planned Parenthood 2019*, 436 P.3d at 1003.

of constitutional rights."[82] Planned Parenthood did not prove here that the physician-only law tends to deter pregnant women from obtaining abortions—or indeed, that it has ever deterred even one woman from obtaining an abortion.

In sum, strict scrutiny does not apply simply because the physician requirement creates a theoretical barrier, or a minor one that patients and Planned Parenthood overcome and that does not impede the fundamental right to choose.

II. The physician-only law survives the applicable constitutional scrutiny.

Because the physician-only law does not substantially impact a woman's right to choose whether and when to have children, it does not violate the constitutional right to privacy, and Planned Parenthood's equal protection challenge premised on that minimally impacted right is not subject to strict scrutiny. The law survives the applicable level of equal protection scrutiny because its differential treatment of patients, APCs, and doctors is sufficiently closely related to compelling and legitimate state interests.

A. Because the physician-only law minimally impacts a fundamental privacy right, it does not violate the right to privacy.

"For the right to privacy to apply, there must be . . . a claim of a substantial infringement, as distinguished from a minimal one."[83] As explained above, no substantial infringement on the fundamental privacy right to choose whether and when to have

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82 *Planned Parenthood 2001*, 28 P.3d at 909 (brackets omitted).

83 *Doe v. Dep't of Pub. Safety*, 444 P.3d at 126-27; *see also Ranney Eng'ring*, 122 P.3d at 222.

children was shown here. This ends the privacy clause[84] analysis.[85] Even if further analysis is warranted under less-than-strict scrutiny for non-substantial privacy burdens, that analysis would duplicate the equal protection analysis discussed below and reach the same result—i.e., the statute passes the applicable level of non-strict scrutiny.

B. The physician-only law bears a close and substantial relationship to compelling and legitimate state interests and therefore does not violate equal protection with respect to the right to abortion.

The superior court erred in concluding that the physician-only law violates the equal protection rights of patients seeking aspiration and medication abortions by treating them differently from patients seeking other care. [Exc. 131-33]

Alaska's equal protection clause mandates equal treatment of those similarly situated.[86] The Court uses a flexible "sliding scale" approach to analyze equal protection claims.[87] The first step—previewed above—sets the level of scrutiny: the more fundamental the right, the stricter the level of scrutiny.[88] But the degree to which the law burdens the right is also a factor: if the burden is minimal then the level of scrutiny is lower.[89] The second step in the analysis focuses on the State's interest: "Depending on

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84 Alaska Const. art. I, § 22.

85 *Ranney Eng'ring*, 122 P.3d at 222; *Doe v. Dep't of Pub. Safety*, 444 P.3d at 126-27.

86 Alaska Const. art. I, § 1.

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

88 *Id.*

89 *Alaska Pacific Assur. Co.*, 687 P.2d at 271 ("The suspicion with which this court will view infringement upon [the constitutional right] depends upon the degree to which the challenged law can be said to penalize exercise of the right. . . This in turn depends

the level of review determined [in the first step], the state may be required to show only that its objectives were legitimate, at the low end of the continuum, or, at the high end of the scale, that the legislature was motivated by a compelling state interest."[90] The third step then considers whether the means are sufficiently "well-fitted" to the ends, given the level of scrutiny: "At the low end of the sliding scale . . . a substantial relationship between means and ends is constitutionally adequate" whereas "[a]t the higher end of the scale, the fit between means and ends must be much closer" and the means must be the "least restrictive alternative."[91]

Here, on the first step, although this case involves a fundamental right, strict scrutiny does not apply because the burden on the right is minimal as discussed above. The physician-only law does not "effectively deter[] the exercise of the fundamental constitution right to reproductive choice."[92] The State therefore needs only a legitimate reason to allow doctors to perform abortions while disallowing APCs to perform abortions despite APCs' being able to perform some other gynecological and obstetrical care.[93] And that reason need not be the least restrictive alternative, but must simply bear a "substantial relationship" to the objectives of the law.[94]

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upon the objective degree to which the challenged legislation tends to deter [exercise of the right].")

90 *Planned Parenthood 2019*, 436 P.3d at 1001.

91 *Id.* at 1001, 1004.

92 *See id.* at 990 (internal quotation marks omitted).

93 *See id.* at 1001.

94 *See id.*

Turning to the second step of the analysis, the superior court erred in concluding that the State has not asserted a compelling interest to support the physician-only law. [Exc. 130] The text and history of the law assert several distinct state interests, some compelling and some legitimate: the safety of pregnant women; women's right to choose; respect for and protection of fetal life; and the integrity, ethics, and cohesive administration of the medical profession. The following discusses the State's interests (the second step of the equal protection analysis) as well as how the physician-only law is well fitted to effectuate them (the third step).

Safety. The State has an interest in protecting the safety of pregnant women, which the physician-only law effectuates. Before the legalization of abortion, women sought underground abortions which led to a "high death toll."[95] The legislature enacted AS 18.16.010(a)(1), in part, to make abortions safer.

Instead of having dangerous illegal abortions, the law promotes safety by authorizing doctors to administer them. Planned Parenthood seems to concede this safety benefit. [R. 2337 (PP pleading recognizing that abortion has become "safer since the [physician-only law] was passed in 1970")] It does not argue that it would be safe for pregnant women to allow the general public to administer abortions. Likewise, Planned Parenthood does not appear to dispute that safe medication and aspiration abortions

[95] Planned Parenthood, Historical Abortion Law Timeline: 1850 to Today, https://www.plannedparenthoodaction.org/issues/abortion/abortion-central-history-reproductive-health-care-america/historical-abortion-law-timeline-1850-today (last visited Feb. 26, 2025).

require highly trained medical professionals. [*See* R. 2337 (arguing only that "*properly trained APCs* can provide abortion just as safely as physicians") (emphasis added)]

Autonomy. Safety aside, the State also has a compelling interest in protecting women's constitutional right to choose whether and when to have children, which this law effectuates. Even before Alaskans amended the constitution to include the right to privacy, the 1970 legislature enacted this law to make pre-viability abortions "a matter of personal belief" and personal choice.[96] This is why the legislature decriminalized abortions when performed by doctors. The legislature recognized this important interest, but it also recognized that the interest was not absolute.

Respect for Fetal Life. The legislature intended to balance this compelling interest in personal autonomy with the sometimes conflicting but also compelling interest in protecting, respecting, and promoting "the possibility of life."[97]

The physician-only law effectuates this purpose too. The balance manifested itself in a law that legalized physician-administered abortions as regulated by the Medical Board.[98] The legislature directed the Medical Board to promulgate "ethical" rules

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[96] 1970 Sen. J. Supp., No. 10 (Mar. 25, 1970) (report by members of the S. Jud. Com. Voting "do pass" in support of SB 527).

[97] 1970 Sen. J. Supp., No. 10 (Mar. 25, 1970) (Minority Report on CSSB 527); *see also* 1970 Sen. J. pp. 792-93 (Apr. 17, 1970) (letter from Gov. Keith Miller to Sen. Pres. Brad Phillips, writing that the "central issue [in an abortion reform bill] is the right to life," and the constitution protects "the life of an unborn child").

[98] AS 18.16.010(a)(1); AS 08.64.105. Remember, the Medical Board does not regulate nurses. AS 08.64.100 (Medical Board's general regulatory authority); AS 08.64.101 (Medical Board's duties); AS 08.64.107 (regulation of physician assistants).

governing abortions,[99] which the Board does. One of the rules that most clearly respects and promotes the possibility of human life requires that abortions of viable fetuses be performed near a NICU,[100] so that if the abortion fails, the NICU can try to protect the new life. Another Board regulation effectuating these goals requires doctors to estimate the gestational age of a fetus before administering an abortion.[101] This ensures that a safe method of abortion is selected and informs whether an abortion can be done at all.

Integrity of Medical Profession. Having only doctors administer this *sui generis* and high-stakes medical intervention both shows respect for fetal life and protects the integrity of the medical profession. Abortion is singularly different from any other medical intervention because it involves the intentional and irreversible termination of burgeoning human life. The closest medical analogue is doctor-assisted suicide, which is a felony in Alaska.[102] As a sign of respect to human life, and to ensure that this medical intervention follows the ethical standards set by the Medical Board, the legislature made a legitimate policy call to allow only doctors—the most educated, experienced, and esteemed class of medical professionals—to administer this unique medical treatment.

While APCs are undoubtedly integral to our healthcare system and go through more training than registered nurses, their training is much less rigorous than doctors'.

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99 AS 08.64.105.

100 12 AAC 40.120(b).

101 12 AAC 40.090.

102 *Sampson v. State*, 31 P.3d 88 (Alaska 2001) (affirming the constitutionality of Alaska's manslaughter statute that criminalizes intentionally assisting suicide and that does not make an exception for doctor-assisted suicide); AS 11.41.120(a)(2), (b).

Doctors go through four years of medical school and then train in residency for three years under the close supervision of other doctors.[103] Residents work up to 80 hours a week, and rotate through different fields, gaining an unparalleled breadth of experience and leaving residency with a holistic understanding of medicine and the human body.[104] Given society's higher cultural expectations of doctors, the legislature made a legitimate policy call to have only them perform abortions.

Administration. Finally, the State has an interest in having a single board, the Medical Board, regulate the administration of abortions, rather than having the Nursing and Medical Boards enact potentially conflicting regulations. To this end, the legislature directed the Medical Board to "adopt regulations necessary to carry into effect the provisions of AS 18.16.010," including setting standards "of professional competency in the performance of abortions," and establishing "care of patients in the performance of an abortion."[105]

The superior court's injunction undercuts this interest because, currently, no regulations cover nurses administering abortions. And were the Nursing Board to promulgate such regulations, there is no guarantee that they would match the Medical Board's, meaning that the professional and ethical administration of abortion would vary depending on whether a doctor or nurse was performing the procedure. Alaska Statute

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103 *See* 12 AAC 40.010.; 12 AAC 40.038.

104 *See* Anupam B. Jena, Harvard Business Review, Is an 80-Hour Workweek Enough to Train a Doctor? (July 12, 2019), https://hbr.org/2019/07/is-an-80-hour-workweek-enough-to-train-a-doctor.

105 AS 08.64.105.

18.16.010(a)(1), the physician-only law, effectuates the legislature's legitimate interest in having a single board regulate the ethical and professional administration of abortions.

Planned Parenthood argues that the physician-only law should be differently tailored to allow abortions not just by doctors, but also by some APCs, when properly trained and supported, and when administering certain methods of abortion. [*See* R. 2399] But this demands too much for a law analyzed under a less exacting standard than strict scrutiny—the law need not be so narrowly tailored or the least restrictive means. Lines must be drawn somewhere, and courts do not require surgical precision.[106]

For similar reasons, the superior court erred in holding that the physician-only law is unnecessary (and thus unconstitutional) because the Medical and Nursing Boards already regulate medicine and nursing and the practice of medicine and nursing without a license is already a misdemeanor. [Exc. 131-32] Because strict scrutiny does not apply, the law need not be the least restrictive means of promoting the State's interests. The legislature permissibly chose to make an abortion by a non-doctor a felony rather than just a sanction by a board or a misdemeanor of practicing without a license. Given the nature of the medical treatment—that it is an intentional life-ending and irreversible treatment—the legislature is entitled to put more stringent guardrails on its use, to prevent

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106 *Cf. Mazurek*, 520 U.S. at 973 (emphasizing, in upholding a physician-only requirement under the federal undue burden test, that "[o]ur cases reflect the fact that the Constitution gives the States broad latitude to decide that particular functions may be performed only by licensed professionals, *even if an objective assessment might suggest that those same tasks could be performed by others.*") (emphasis original).

its misuse.[107]

In short, the law's differential treatment of providers with respect to patients seeking abortion care bears a close and substantial relationship to the State's compelling and legitimate state interests and is therefore constitutional.

C. The physician-only law is more than fairly related to legitimate state interests and therefore does not violate equal protection with respect to the economic rights of APCs.

The superior court also erred in concluding that the law violates the equal protection rights of APCs whose scope of practice would include medication and aspiration procedures but for AS 18.16.010(a)(1). [Exc. 133]

Because this second equal protection theory hinges not on patients' fundamental rights but rather on APCs' interest in engaging in an economic endeavor within a particular industry, only the minimal level of scrutiny applies.[108] "Minimum scrutiny requires only a fair and substantial relation between the means and the legitimate goals of the challenged law,"[109] which the State has established. For the same reasons discussed above, the State's different treatment of physicians and APCs in the abortion context is more than fairly related to the State's legitimate interests.

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107 *Cf. Sampson*, 31 P.3d 88.

108 *State v. Schmidt*, 323 P.3d 647, 663 (Alaska 2014) ("Government action that burdens only economic interests generally receives only minimum scrutiny."); *Squires v. Alaska Bd. of Architects, Eng'rs & Land Surveyors*, 205 P.3d 326, 340 (Alaska 2009) ("Although the right to practice one's profession is protected by the due process clause, it is not 'fundamental,' and it may be regulated so long as those regulations are reasonably related to a legitimate purpose.").

109 *Schmidt*, 323 P.3d at 663.

While the State more than surpasses this low standard, it is notable that Planned Parenthood has not actually shown that APCs' economic interests are at stake. Planned Parenthood is the only public provider of abortion care in Alaska. [Tr. 41; Exc. 113] It does not intend to open any rural clinics, regardless of the superior court's injunction. [Tr. 408] Planned Parenthood's witnesses repeatedly stressed Alaska's low abortion volume [Tr. 110, 368-69, 650, *see also* Tr. 710, 716] and how its clinics here are already meeting Alaska's abortion needs. [Tr. 374, 650-51; Exc. 1-15, 122] Planned Parenthood has therefore not shown that its APCs have been or would be deprived of any additional employment or income potential because of the physician-only law. And even if it had shown this, the State has met its burden under the minimal scrutiny applicable to such claims.

CONCLUSION

For these reasons, the Court should reverse the superior court's injunction and conclude that AS 18.16.010(a)(1) is constitutional.