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IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

PLANNED PARENTHOOD OF THE GREAT NORTHWEST, HAWAII, ALASKA, INDIANA, KENTUCKY, a Washington corporation,	)	
Plaintiff,	)	
v.	)	
STATE OF ALASKA; et al.	)	
Defendants.	)	Case No. 3AN-19-11710 CI

STATE DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

I. INTRODUCTION

Planned Parenthood has challenged the constitutionality of a fifty-year-old statute that decriminalized abortion in Alaska so long as it is performed by a physician licensed by the State Medical Board. It argues that advances in medicine and the structure of healthcare professions has rendered the statute unconstitutional. But the constitutionality of statutes is typically evaluated by reference to the purposes and intent of the legislature in enacting them and the statute would withstand even strict scrutiny evaluated on the record in 1970. Planned Parenthood's claim is therefore that this statute has somehow aged out of constitutionality. But despite the unusual posture of its claim, Planned Parenthood has declined to identify the threshold or border that was crossed to make this once constitutional law unconstitutional. Indeed, Planned Parenthood's position is that it need only offer vague, impressionistic and effectively untestable

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assertions by its own providers that patients are delayed as a result of the law to meet its burden to show a constitutional violation. This is not the law. To the contrary, plaintiffs have a meaningful burden to produce evidence that a law burdens a constitutional right before a court need apply any level of scrutiny to that law—otherwise, the presumption of constitutionality means nothing. And a court should exercise particular restraint when considering a claim that an originally constitutional law is now so outdated that it violates the constitution, taking plaintiffs' evidentiary burden seriously. Here, because Planned Parenthood has failed to offer admissible evidence that the law burdens access to abortion, the State asks this Court to grant summary judgment in its favor and dismiss Planned Parenthood's complaint.

II. FACTS

A. AS 18.16.010(a)(1)[1] was enacted in 1970 as part of legislation legalizing the provision of abortion.

In 1970, the Alaska Legislature enacted CSSB 527 (HWE), which decriminalized abortion. In so doing, the Legislature required that an abortion be performed by a physician licensed by the State Medical Board under AS 08.64.200.

The licensing requirement was not enacted as part of a statutory scheme intended to limit or restrict a women's right to abortion care; just the opposite. The challenged

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[1] The challenged statute was originally enacted in ch. 103 SLA 1970 and was part of Alaska's criminal statutes. The statute was renumbered as AS 18.16.010 in 1978.

statute was enacted as part of legislation that made abortion legal for the first time in the State of Alaska.[2]

The Legislature's decision to restrict the provision of abortion care to physicians is not surprising – when the licensing requirement was passed, abortion was an invasive, surgical procedure.[3] Since the early-1970s, however, medical technology has advanced, and "medication abortions" are now available through a combination of two medications – mifepristone and misoprostol – which were approved by the U.S. Food and Drug Administration in 2000.[4]

Here, despite its theory that the statute has become "outdated" due to advancements in the practice of medicine, Planned Parenthood has not engaged in any lobbying efforts or otherwise attempted to use the democratic process to change the law, nor has Planned Parenthood brought the alleged access problem to the attention of the Department of Health and Social Services or the Board of Medicine.[5]

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[2] As a result, this case is fundamentally different from cases arising from newly-enacted legislation specifically aimed at limiting a woman's access to abortion care. *See, e.g., Planned Parenthood of the Great Northwest and the Hawaiian Islands v. Wasden*, 406 F.Supp. 3d 922 (D. Idaho 2019) (challenging licensing requirement enacted in 2000).

[3] Exhibit A, Wein Deposition, p. 177, lines 18-23; *see also* Exhibit M, Ramesh Deposition at p. 21, lines 12-21 (noting that "in the eighties and nineties there were many advancements in the provision of safer surgical abortion or procedures.").

[4] Exhibit M, Ramesh Deposition at p. 21, lines 8-11.

[5] *See, e.g.*, Exhibit B, Crum Deposition p. 133, line 23 – p. 135, line 16 (testifying that a lack of providers to perform abortions has not been brought to DHSS's attention, nor have Medicaid assessments identified a shortage of abortion providers); Exhibit A, Wein Deposition, p. 254, lines 3-24 (Planned Parenthood has not approached the Medical Board and asked it to advocate for repeal of AS 18.16.010); Exhibit I, Bender Deposition, p. 116, lines 12-19.

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B. The reality of healthcare delivery in Alaska.

Difficulties accessing healthcare are a fact of life for many Alaskans, due in part to what Adam Crum, the Commissioner of the Department of Health and Social Services (DHSS), describes as "the tyranny of distance."[6] Depending on where an Alaskan resides, he or she will likely have to plan in advance for healthcare. Delays in scheduling appointments are commonplace and expected.[7]

Even Planned Parenthood acknowledges the inherent limitations on the delivery of healthcare across Alaska. For example, when cross-examined about her testimony that 86 percent of Alaskan boroughs lack an abortion provider, Planned Parenthood's Alaska State Medical Director, Dr. Tanya Pasternack,[8] admitted that Planned Parenthood's own standard of care prohibits it from providing abortion care in communities other than the ones in which it has operated clinics – Anchorage, Juneau, Soldotna, and Fairbanks.[9]

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6 Exhibit B, Crum Deposition p. 105, lines 17-18.

7 Exhibit B, Crum Deposition, p. 142, lines 6-7 ("That is – the expectation about living in a – say, living in a frontier state with minimal road system connectivity.") The realities identified by Commissioner Crum are present even in Anchorage. For example, Planned Parenthood's Alaska State Medical Director, Dr. Tanya Pasternack, testified that it is "not typical" for a patient to get a same day appointment at her OB-GYN clinic. When asked if appointments were typically available on the next day, Dr. Pasternack answered: "It can happen, but it doesn't often." Exhibit C, Pasternack Deposition at p. 138, lines 5-23.

8 Exhibit C, Pasternack Deposition, p. 5, line 19 – p. 6, line 24. Dr. Pasternack is responsible for overseeing Planned Parenthood's team of per diem physicians across the State and is responsible for hiring new physicians. Exhibit C, Pasternack Deposition, p. 8, lines 6-8.

9 Exhibit C, Pasternack Deposition, p. 48, line 9 – p. 50, line 10.

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To combat the "tyranny of distance" and the fact that some communities simply are not large enough to support a full-time provider, Alaska utilizes a "hub and spoke" model of healthcare delivery. Commissioner Crum explained:

> So, as an example, you look at Bethel, in the Yukon-Kuskokwim region has 56 outlying villages not connected by road, its's primarily by boat or by train. All of those villages will use Bethel, which has a health center or hospital as their primary means of healthcare. They may have some clinics where nurses may rotate in and out, but primarily, if they need healthcare, they will go to Bethel. If they need complicated surgeries or specialty care, then Alaska natives in rural Alaska will come into Anchorage to get services at the Alaska Native Mental – Medical Center, or ANMC, which is managed by Alaska Native Tribal Health Consortium.[10]

What's more, the State is actively engaged in efforts to expand access to healthcare for Alaskans in rural communities, meeting with local communities and tribal health providers to help them prepare for healthcare emergencies, and enacting a new telehealth bill that made permanent various changes adopted during the pandemic.[11] As Commissioner Crum explained, the new law

> allows a lot more flexibility on who can deliver what services over telehealth, and connecting rural Alaskans, knowing that distance is always going to be one of the issues, but how do we make sure people are getting timely…timely appointments in order to actually see a license professional…So if there is services that need to be provided out of region…they get that in a sooner process…and then in turn…they would be referred on and already traveled to a hub community for an in person consult.[12]

Sometimes, professional standards of care do not allow for healthcare to be administered in a rural community (see Dr. Pasternack testimony, *infra*) or via

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10 Exhibit B, Crum Deposition, p. 69, line 20 – p. 70, line 13.

11 Exhibit B, Crum Deposition, p. 139, line 9 – p. 141, line. 23.

12 Exhibit B, Crum Deposition, p. 140, line 25 – p. 141, line 23.

telehealth. In those instances, low income Alaskans have access to Medicaid coverage for travel expenses,[13] including for abortion services.[14]

Identifying access problems is within the purview of the DHSS. Accordingly, DHSS prepares "Primary Care Access Reports," which show and highlight areas of concern that have been brought to DHCC, not only by public health officials, but also by Tribal Health organizations and other provider groups around the state.[15] Commissioner Crum explained:

> [D]uring these intended surveys, as funded by HRSA, the Health Care Resources and Services Agency, which is a federal agency under Federal Health & Human Services, it brings forward and highlights what areas around the state actually identify as a lack of need.[16]

Importantly, a lack of providers available to perform abortions is *not* an issue that has been raised with DHSS.[17]

In sum, practical realities make access to healthcare in rural Alaska a challenge. But help is available, including for Alaskans seeking abortion care in communities where the standard of care does not allow it to be provided. And DHSS has not identified an access problem with respect to abortion.

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[13] Exhibit B, Crum Deposition, p. 142, line 9 – p. 145, line 24; *see also* Crum Deposition, p. 77, lines 9-18.

[14] Exhibit B, Crum Deposition, p. 145, lines 19-24 ("[A]bortion is a Medicaid eligible service, and so anybody who meets the medical necessity standpoint, based through their normal referral aspect, is eligible to receive services, no barriers or obstructions there.").

[15] Exhibit B, Crum Deposition, p. 23, line 25 – p. 24, line 7.

[16] Exhibit B, Crum Deposition, p. 24, lines 8-14.

[17] Exhibit B, Crum Deposition, p. 135, lines 2-16.

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C. Planned Parenthood's business model in Alaska.

i. Planned Parenthood's APRNs and per diem physicians.

Planned Parenthood staffs its Alaska clinics with two types of healthcare providers: Advanced Practice Registered Nurses (APRNs) and per diem physicians.

Planned Parenthood's per diem physicians typically have jobs at other clinics, and they are paid "per procedure performed;" they also receive a minimum amount of compensation per day just for being present at the clinic, irrespective of whether they treat any patients.[18] Planned Parenthood's APRN's, on the other hand, are salaried.[19]

Planned Parenthood charges the same amount for an abortion, regardless of whether it is performed by an APRN or a physician.[20]

ii. Abortion availability and telehealth.

Historically, Planned Parenthood's per diem physicians have offered abortion care as follows:[21]

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18 Exhibit C, Pasternack Deposition, p. 15, line 16 – p. 16, line 4.

19 Exhibit C, Pasternack Deposition, p. 16, lines 8-10.

20 Exhibit C, Pasternack Deposition, p. 125, lines 13-18.

21 *See* Affidavit of Dr. Tanya Pasternack dated June 12, 2021, pp. 8-9 (¶ 35); *see also* Errata Affidavit of Dr. Tanya Pasternack, pp. 1-3 (correcting prior affidavit).

	Anchorage	Fairbanks	Juneau	Soldotna[22]
Medication Abortion	1-2 days per week	Weekly	Weekly	Weekly
Aspiration Abortion	Weekly	1 day per month (2 days per month since 2019)	Monthly	Not offered[23]

But those numbers don't tell the whole story.

Since approximately 2013, Planned Parenthood has offered medication abortions via telehealth.[24] Conducting a procedure via telehealth allows a patient physically present at any one of Planned Parenthood's clinics to receive a medication abortion from a per diem physician present at any one of Planned Parenthood's clinics.[25] For example, a per diem physician at Planned Parenthood's Fairbanks clinic could administer a medication abortion to a patient at Planned Parenthood's Juneau clinic via telehealth in the event a physician was not available in Juneau.[26]

While the exact details are unclear, Planned Parenthood appears to take the availability of telehealth into account when scheduling medication abortions, which

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22 Planned Parenthood's Soldotna clinic was closed at the end of May 2022 because Planned Parenthood could not financially support it. Exhibit C, Pasternack Deposition, p. 14, line 18 – p. 15, line 1.

23 When it was open, the Soldotna clinic was not physically equipped to provide aspiration abortions consistent with the standard of care. Exhibit C, Pasternack Deposition, p. 49, line 23 – p. 50, line 22.

24 Exhibit C, Pasternack Deposition, p. 33, lines 8-12.

25 Exhibit C, Pasternack Deposition, p. 29, line 11 – p. 30, line 5 (explaining that during the pandemic, the per diem could be at a health center, or even at home with appropriate IT set-ups).

26 *Id.*

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likely results in more availability than Planned Parenthood's high-level evidence (*e.g.*, testimony that abortions are available "weekly") suggests. Dr. Pasternack explained:

> We use a centralized scheduling phone center, so the patient is most commonly not communicating directly with a specific location staff. I don't know all the details of how they accommodate patients and schedule them, but my understanding is that a medication abortion time slot would never require – the patient would always – if there was a time slot available on a physician's schedule, be given the opportunity to do that via telehealth.[27]

iii. Planned Parenthood's per diem physician staffing.

Planned Parenthood's Alaska clinics are currently staffed by a roster of eight per diem physicians.[28] According to Dr. Pasternack, Planned Parenthood "functions really well" at that number.[29] When asked if Planned Parenthood has explored bringing on additional per diem physicians to address the alleged access problem, Dr. Pasternack indicated that, while that might make sense "externally," it would be disruptive to the day-to-day flow of things at Planned Parenthood.[30]

While prior testimony from Planned Parenthood witnesses suggested a shortage of physicians willing to perform abortions, Planned Parenthood's documents tell another story. In fact, Planned Parenthood has recently turned away multiple physicians that want to perform abortions, consistently taking the position that it is "fully

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27 Exhibit C, Pasternack Deposition, p. 108, lines 7-22.

28 Exhibit C, Pasternack Deposition, p. 143, lines 16-25.

29 Exhibit C, Pasternack Deposition, p. 143, lines 20-24.

30 Exhibit C, Pasternack Deposition, p. 143, line 16 – p. 144, line 24.

staffed."[31]

For example, in September 2018, a provider in Nome reached out to Planned Parenthood about providing abortions.[32] But Planned Parenthood turned the provider away, explaining that it was "fully staffed with providers…"[33] One provider even offered to travel from Bethel to Planned Parenthood's clinics to perform abortions, explaining: "I am pursuing a position as a hospitalist in Bethel, AK, but I was wondering if there were opportunities to do procedures at your clinic in Anchorage. I would be happy and grateful to fly in and work with your amazing organization."[34] But they too were turned away with the explanation that Planned Parenthood did not need additional doctors to provide abortions.[35]

Dr. Pasternack even suggested one physician, who was interested in performing abortions at Planned Parenthood's Alaska clinics, could help staff clinics in the lower 48 because "we don't have any openings for physicians right now at our Alaska PP sites."[36]

In the case of physicians Planned Parenthood turned away on the basis that it was fully staffed, Planned Parenthood failed to consider or conduct any analysis of whether there was a way to bring the physician on board to help alleviate the alleged access

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31 *See* Exhibit D.

32 *See* Exhibit E.

33 *Id*.

34 *See* Exhibit F.

35 *Id.*

36 *See* Exhibit G.

problem.[37]

D. Statistical evidence does not point to an access problem.

One way to objectively evaluate whether a state has an access problem with respect to a specific type of healthcare is through the use of statistics.[38] Here, the State's expert witness, Dr. Michael New,[39] evaluated the data produced by Planned Parenthood in discovery, along with additional publicly-available data, to determine if the data indicated an access problem. He drew four conclusions.

i. Alaska's abortion rate is consistent with other comparable states.

First, Dr. New concluded Alaska's abortion rate is broadly consistent with that of other comparable U.S. states:

> Statistical analysis of state abortion rates in the U.S. indicates that given the number of abortion facilities in Alaska per capita, Alaska's per capita income, the age and racial demographics of Alaska women of childbearing age, public attitudes toward abortion, and Alaska's policy regarding abortion – the abortion rate in Alaska is broadly consistent with that of other comparable U.S. states. Overall, the actual abortion rate in Alaska given its economic, demographic, attitudinal, and policy characteristic is broadly similar to what statistical model would predict. Furthermore, the percentage of unintended pregnancies in Alaska that

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[37] *See, e.g.*, Exhibit C, Pasternack Deposition, p. 168, lines 6-10, p. 170, lines 2-7, p. 174, lines 7-10.

[38] *See, e.g.*, testimony of Dr. Michael New, *infra*; *see also* Exhibit H, Spetz Deposition, p. 11, line 17 – p. 12, line 4 ("…most of my research focuses on data and numbers, statistics; you know., sometimes fairly sophisticated statistical analyses…but generally using numbers as opposed to you know, that's a really interesting questioning…").

[39] Dr. New holds a Ph.D. in political science and a M.S. in statistics, both from Stanford University. After he completed his Ph.D., he completed a two year post-doctoral fellowship at the Harvard-MIT Data Center. He has an extensive background in statistics, and his areas of expertise include fiscal policy, direct democracy, and mortality policy. New Affidavit, p. 1 (¶ 2); *see also* New Report, p. 24.

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result in an abortion is very close to the 50-state average. This is evidence that the Licensed Physician Requirement did not create a substantial access problem for Alaska women who are seeking abortions.[40]

ii. Planned Parenthood's data does not show an access problem.

Second, Dr. New concluded that Planned Parenthood's pre-injunction data fails to effectively show that the licensing requirement creates an access problem.[41] For example, Planned Parenthood's wait time data failed to take into account that some women seeking abortions may not accept the earliest appointment offered to them.[42] The data also failed to consider missed appointments, rescheduled appointments, or women who simply never showed up for an appointment.[43]

Planned Parenthood also failed to collect key data, including (1) the number of women obtaining abortions who lived more than 50 or 100 miles from the nearest abortion facility; (2) the number of abortions paid for by Medicaid; (3) the number of women who wanted a medication abortion, but obtained an aspiration abortion instead due to gestational age limitations; and (4) the number of women who made abortion appointments, but never showed up.[44]

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40 New Affidavit, p. 3 (¶ 11); *see also* New Report, p. 2.

41 New Affidavit, pp. 3-4 (¶ 12); *see also* New Report, p. 2.

42 *Id.*; *see also* New Report, p. 2.

43 *Id.*; *see also* New Report, p. 2.

44 New Affidavit, p. 4 (¶ 13); *see also* New Report, p. 3. Planned Parenthood's own expert, Dr. Spetz, explained that a data-intensive study could be designed to evaluate whether the licensing requirement presents an access problem. Exhibit H, Spetz Deposition, p. 47, line 8 – p. 52, line 1.

iii. Incidence of abortion did not materially increase when the licensing requirement was lifted.

Third, Dr. New concluded that Planned Parenthood's post-injunction data fails to show a statistically significant increase in the incidence of abortion in the months after the preliminary injunction was issued. Specifically, Dr. New opined:[45]

> For statisticians to be statistically confident that one mean is greater than the other, they typically want to be at least 90 percent certain that the difference did not result from chance variation in the data. Looking at it another way, statisticians would say that they are statistically confident that one mean is greater than another if there is less than a 10 percent chance that the difference in means would have been caused by chance variation within the data.
>
> A difference of means test conducted using a SPSS 25.0 statistics package found that the increase in the monthly number of abortions after the injunction failed to reach conventional levels of statistical significance. In other words, we cannot be 90 percent certain that the increase in monthly abortions after November 2021 was due to the removal of the Licensed Physician Requirement. In layman's terms, this means that there is a strong possibility that the increase in the number of monthly abortions performed in Alaska was due to either chance variation or random fluctuations in the data.

iv. Wait times were not reduced when the licensing requirement was lifted.

Finally, Dr. New concluded Planned Parenthood's post-injunction data fails to show a reduction in wait time after the preliminary injunction was issued. Instead, the wait times at multiple Planned Parenthood clinics actually increased.[46]

E. Planned Parenthood's evidence of an access problem.

Planned Parenthood's proof stands in stark contrast to the statistical evidence presented by Dr. New and the Primary Care Access Reports described by Commissioner

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45 New Affidavit, pp. 6-7 (¶¶ 20-21); *see also* New Report, p. 5.

46 New Affidavit, pp. 9-12 (¶¶ 29-33); *see also* New Report, p. 9.

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Crum. It is vague, anecdotal, and incapable of cross examination.

For example, despite retaining Dr. Joanne Spetz, a testifying expert witness with significant experience in quantitative research regarding access to care,[47] Planned Parenthood did not ask Dr. Spetz to quantify the alleged access problem here, nor has Dr. Spetz undertaken any independent evaluation of access to abortion in Alaska.[48] Dr. Spetz admitted such study was possible, but she did not conduct one.[49]

Planned Parenthood's fact witnesses fared no better. For instance, when asked how often a patient desired a medication abortion, but was forced to obtain an aspiration procedure because she was delayed past the cut-off, Dr. Pasternack responded: "I would hear that statement a few times a year."[50] But Dr. Pasternack was unable to identify any specific patients that allegedly faced that predicament.[51]

She offered similar testimony about the number of patients per year who wanted an abortion of either type, but were unable to get one due to scheduling delays. With respect to those patients, Dr. Pasternack speculated that the number was "more than

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47 Exhibit H, Spetz Deposition, p. 9, lines 2-15 (explaining her work as a healthcare economist).

48 Exhibit H, Spetz Deposition, p. 47, lines 3-7 (admitting she has not conducted any studies related to access to abortion services).

49 Exhibit H, Spetz Deposition, p. 47, line 3 – p. 52, line 1 (explaining the process she would follow to address whether the licensing requirement causes an access problem).

50 Exhibit C, Pasternack Deposition, p. 84, line 25 – p. 85, line 4. When asked if she could identify the patients that preferred a medication abortion, but were delayed past the cut-off, Dr. Pasternack responded: "No." *Id*.

51 Exhibit C, Pasternack Deposition, p. 84, line 25 – p. 85, line 4.

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on[e] and less than 20."[52]

The testimony of Amy Bender, Planned Parenthood's lead APRN, was consistent with Dr. Pasternack's. When asked how many patients who sought a medication abortion before the entry of the injunction were unable to obtain the procedure because they could not get an appointment before the time for medication abortion ran out, she responded: "I can think of, during my course of four years, I can count on – you know, ten times that that's happened, but that would be *pure speculation*. I have no way of tracking that."[53] Ms. Bender was similarly unable to say how many patients who expressed a desire for medication abortion were unable to get an abortion at all due to difficulty scheduling care.[54]

When asked about patients who missed the opportunity to receive even an aspiration abortion due to difficulties scheduling care, Ms. Bender again offered nothing more than assumptions and speculation:

> I mean, I can only speak to patients that I've heard that. I know it happens – I *assume* it happens more regularly. But I would *speculate* and estimate maybe once a month. I think especially our folks in rural communities have a lot of barriers to care and accessing us, and it can take a long time sometimes between the time that they desire to have an abortion to the time that they're actually scheduled for that abortion.[55]

And despite interacting with patients regularly, Ms. Bender likewise has no knowledge of any effort by Planned Parenthood to collect the data necessary to reliably

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52 Exhibit C, Pasternack Deposition, p. 118, line 8 – p.120, line 13.

53 Exhibit I, Bender Deposition, p. 68, lines 7-22 (emphasis added).

54 Exhibit I, Bender Deposition, p. 71, lines 4-10.

55 Exhibit I, Bender Deposition, p. 90, line 19 – p. 91, line 21 (emphasis added).

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assess whether the licensing requirement causes an access problem.[56] In short, Planned Parenthood has not quantified the alleged access problem. Instead, it offers only vague anecdotal accounts and impressions.

In addition to their inability to quantify the alleged access problem, both Ms. Bender and Dr. Pasternack admitted that assessing any potential burden on a patient based upon delays in scheduling would have to occur on a patient-by-patient basis, since each patient's individual circumstances are different.[57] But despite this admission, the record is devoid of any specific patient accounts.

F. Alaska's licensing requirement is consistent with the law in the majority of other states.

Planned Parenthood characterizes Alaska's licensing requirement as "outdated" and "out-of-step" with APC's role in healthcare systems across the nation. Objectively, that is not the case. But one of Planned Parenthood's expert witnesses, Dr. Joanne Spetz, admitted APCs are only permitted to perform medication abortions in 16-18 states.[58] And only 10-11 states permit APCs to perform aspiration abortions.[59]

Planned Parenthood's fact witnesses are generally in agreement. For example, its medical director, Dr. Tanya Pasternack, thought that "[a]bout 20" states permit APCs to

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56 Exhibit I, Bender Deposition, p. 81, lines 14-22.

57 Exhibit I, Bender Deposition, p. 119, lines 2-22; Exhibit C, Pasternack Deposition, p. 136, line 10 – p. 137, line 6.

58 Exhibit H, Spetz Deposition, p. 54, lines 16-19.

59 Exhibit H, Spetz Deposition, p. 54, lines 20-24.

perform medication abortions, and "[a]bout 15" states permit APCs to perform aspiration abortions.[60]

III. LEGAL STANDARDS.

Planned Parenthood alleges that the licensed-physician requirement violates its patients' fundamental rights to privacy and liberty and denies both its patients and APRNs the equal protection of the law.

"When the state encroaches on fundamental aspects of the rights to privacy or liberty, it must demonstrate a compelling governmental interest and the absence of a less restrictive means to advance that interest."[61] The Alaska Supreme Court has held that abortion is a fundamental right, and thus laws infringing on that right are subject to strict scrutiny.[62] While Alaska's equal protection analysis is somewhat similar, there is one key difference—the court must first engage in a "classification" analysis to identify the two similarly situated groups treated differently by the statute.[63]

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60. Exhibit C, Pasternack Deposition, p. 65, lines 7-12); *see also* Exhibit I, Bender Deposition, p. 35, line 22 – p. 36, line 12) (identifying six states that allow APRNs or APCs to perform abortions).

61 *Sampson v. State*, 31 p.3d 88, 91 (Alaska 2001).

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

63 *Planned Parenthood of The Great Northwest v. State*, 375 P.3d 1122, 1137–38 (Alaska 2016) (*Planned Parenthood IV*) ("Step one of our core equal protection analysis requires evaluating the importance of the personal right infringed upon to determine the State's burden in justifying its differential infringement. It has long been established that the Alaska Constitution's privacy clause guarantees the fundamental right to choose between pregnancy termination and carrying to term.[83] And it has long been established that a law burdening the fundamental right of reproductive choice demands strict scrutiny.").

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But these tests do not automatically demand strict scrutiny for any law or regulation relating to abortion, regardless of its impact. Rather, "[a] party raising a constitutional challenge to a statute bears the burden of *demonstrating the constitutional violation*."[64]

In other words, Planned Parenthood must produce admissible evidence that the law actually infringes on the right to reproductive choice. And Alaska courts still begin with a presumption that a statute is constitutional, even when the statute relates to abortion: "A presumption of constitutionality applies, and doubts are resolved in favor of constitutionality."[65] When considering a facial constitutional challenge, the court should uphold a statute "even if it might occasionally create constitutional problems in its application, as long as it 'has a plainly legitimate sweep.'"[66]

Applying those rules here, Planned Parenthood must demonstrate, through admissible evidence, that the physician licensing statute imposes an unconstitutional access problem in more than occasional circumstances. As set forth below, it has not done so.

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64 *State v. Planned Parenthood of the Great Northwest*, 436 P.3d 984, 992 (Alaska 2019) (*Planned Parenthood V*) (emphasis added) (citing *State, Dep't of Revenue v. Andrade*, 23 P.3d 58, 71 (Alaska 2001)).

65 *Planned Parenthood V*, 436 P.3d at 992 (emphasis added) (citing *Andrade*, 23 P.3d at 71). *See also*, *Planned Parenthood of The Great Nw. v. State*, 375 P.3d 1122, 1133 (Alaska 2016) (*Planned Parenthood IV*) ("We begin by noting that a challenge to a statute 'must overcome a presumption of constitutionality.'").

66 *Planned Parenthood IV*, 375 P.3d at 1133 (citing *Planned Parenthood of Alaska*, 171 P.3d 577, 581 (Alaska 2007) (*Planned Parenthood III*).

IV. ARGUMENT

Planned Parenthood contends the physician licensing statute is unconstitutional for three reasons: (i) it violates "Plaintiff's patients' right to privacy;" (ii) it "infringes upon Plaintiff's patients' fundamental right to medical and reproductive autonomy;" and (iii) it "violates the equal protection rights of Plaintiff and its patients."[67]

While the claims it asserts on behalf of its patients are facial challenges, Planned Parenthood asserts an "as applied" challenge on behalf of "APCs who seek to provide early abortion and miscarriage care."[68]

Planned Parenthood is wrong as a matter of law. The physician licensing statute was clearly constitutional when the legislature enacted it in 1970, and Planned Parenthood does not dispute this. Though medical technology may have changed with the passage of time, Planned Parenthood has not shown that the statute imposes an unconstitutional burden on the fundamental right to abortion. Moreover, the classifications Planned Parenthood puts forth in support of its equal protection claim fail as a matter of law. Accordingly, the State is entitled to summary judgment on all of Planned Parenthood's claims, and it asks the court to grant its motion.

A. The licensed physician requirement was constitutional when it was enacted.

There can be no serious dispute that when the legislature enacted the licensed

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[67] Complaint at ¶. 12. *See also* Complaint at ¶¶ 112 (right to privacy), 114 (right to liberty), and 116-118 (equal protection).

[68] *Id.* at ¶ 12. In its Claims for Relief, Planned Parenthood also alleges that the licensing statute violates the equal protection rights of pregnant women. *Id.* at ¶¶ 116-117.

physician requirement in 1970 it did not violate either the federal or state constitution.

First, the challenged statute actually *expanded access* to abortion, which was previously illegal, by creating an exception to the law prohibiting abortion.[69] Thus, Planned Parenthood's characterization of the law as "the APC ban" is misleading. The statute says nothing about APCs, and its purpose was to permit legal abortion in Alaska, not to ban anything.

Second, even before *Dobbs*,[70] physician licensing requirements were repeatedly upheld by the United States Supreme Court as consistent with the federal constitution.[71] And, even after Alaskans voted to add constitutional privacy protections to the state constitution, the law would have survived strict scrutiny because it was consistent with best medical practices and the shape of the health care profession in the 1970s. Planned Parenthood cannot seriously dispute this; indeed, it recognized this fact in its motion for preliminary injunction, when it argued that: "[a]t bottom, the APC Ban is a poor fit for the State's interest in protecting patients because it was enacted in 1970, over 50 years

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69 Alaska Statute AS 18.16.010(a)(1) provides: "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."

70 *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022).

71 *See e.g.*, *Roe v. Wade*, 410 U.S. 113, 165 (1973) ("The State may define the term 'physician,' … to mean only a physician currently licensed by the State, and may proscribe any abortion by a person who is not a physician as so defined."); *Connecticut v. Menillo*, 423 U.S. 9, 11 (1975) ("…prosecutions for abortions conducted by nonphysicians infringe upon no realm of personal privacy secured by the Constitution against state interference."); *Mazurek v. Armstrong*, 520 U.S. 968 (1997) (reversing Ninth Circuit decision holding that plaintiffs had shown sufficient likelihood of succeeding on merits of challenge to Montana's licensed physician requirement to meet threshold for preliminary injunctive relief).

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PHONE: (907) 269-5100

ago, *when safe, legal medication abortion had not even been developed (let alone studied, or approved by the FDA) and APCs did not exist as a category of authorized health care providers in Alaska*."[72]

Thus, Planned Parenthood asks the Court to hold developments in medicine and professional licensing rendered an indisputably constitutional law, enacted to expand access to abortion, unconstitutional because it now unduly burdens access.

This distinguishes the case from Alaska's other abortion precedents, which all involved a change in the law imposing new restrictions on access to abortion.[73] Here, it is not a change in the law that is alleged to have limited access to abortion. Rather, Planned Parenthood's case is essentially that the law has been overtaken by innovations in both medical procedures for terminating pregnancies and in the structure of the health care professions and, as a result, abortion access could be improved without risking public safety if the law was amended to allow APCs to provide abortion care.

B. The proper solution for an outdated statute is legislative change.

The Alaska Constitution vests legislative power in the Alaska Legislature.[74] Updating laws to reflect current conditions is a quintessentially legislative function; and

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72 Planned Parenthood Motion for Preliminary Injunction, p. 21.

73 *Valley Hospital Ass'n, Inc. v. Mat-Su Coal. for Choice*, 948 P.2d 963 (Alaska 1997) (ban on abortion in hospital); *Planned Parenthood I*, 28 P.3d 904 (ban on Medicaid funding for abortion); *State v. Planned Parenthood of Alaska*, 35 P.3d 30, 34–35 (Alaska 2001) (*Planned Parenthood II*) (requiring parental consent for abortion); *State v. Planned Parenthood III*, 171 P.3d 577 (same); *Planned Parenthood IV*, 375 P.3d 1122 (parental notification for abortion); *Planned Parenthood V*, 436 P.3d 984 (restriction on Medicaid funding for abortion).

74 *See e.g., Jones v. State, Dep't of Revenue*, 441 P.3d 966, 981 (Alaska 2019) (quoting *Alaska Pub. Interest Research Grp. v. State*, 167 P.3d 27, 35 (Alaska 2007)).

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PHONE: (907) 269-5100

one that the legislature is best positioned to undertake. The legislative process involves hearings at which all stakeholders can be heard on proposed changes to the law, multiple rounds of consideration and input from many lawmakers; and the process plays out in the public eye.

In contrast, courts "are not legislators, policy makers, or pundits charged with making law or assessing the wisdom of legislative enactments."[75] And although the court's function is certainly to evaluate the constitutionality of legislation, it is less clear how the court should assess a law that was undisputedly constitutional when enacted against a challenge that time has rendered it unconstitutional.

The U.S. Supreme Court faced a similar situation in *Brotherhood of Locomotive Firemen & Enginemen v. Chicago, Rock Island & Pacific Railroad Co.*[76] There, the Arkansas legislature passed laws in the early 20th-century that set personnel requirements for trains operating in the state,[77] and the Court affirmed the constitutionality of those laws soon after they were passed.[78]

A half-century later, plaintiffs challenged the laws again, arguing that technological changes made the staffing laws obsolete and therefore arbitrary and unconstitutional.[79] The district court agreed with the plaintiffs and held that the laws were "unreasonable and oppressive" and therefore violated the Due Process Clause of

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75 *Planned Parenthood III*, 171 P.3d at 579.

76 393 U.S. 129 (1968).

77 *Id.* at 133.

78 *Id.* at 130.

79 *Id.* at 132.

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the Fourteenth Amendment.[80] But the Supreme Court reversed.

In doing so, it compared the facts found by the legislature related to appropriate staffing levels for trains operating in Arkansas[81] with those found by the district court. It focused on the lower court's conclusion that the full-crew requirements had "no substantial effect on safety of operations"[82] and the district court's finding that even if the statutory requirements added an increment of safety, such an increment was negligible and not worth the cost.[83]

In upholding the statute a second time, the Court disapproved of the district court's crediting its own fact-finding over the legislature's, even though the legislature had reached its conclusions a half-century earlier: "We think it plain that in striking down the full-crew laws on this basis, the District Court indulged in a legislative judgment wholly beyond its limited authority to review state legislation under the Commerce Clause."[84] Moreover, the Court held that the question of safety was "essentially a matter of public policy" and that "public policy can, under our constitutional system, be fixed only by the people acting through their elected representatives."[85]

The Court emphasized the deference that the judiciary owed the legislative

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80 *Id.* at 132-33.

81 *Id.* at 134.

82 *Id.* at 136.

83 *Id.*

84 *Id.*

85 *Id.* at 138.

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branch when a legislature has given consideration to factual questions involving public safety—even if that consideration was undertaken decades earlier:

> Undoubtedly heated disputes will continue as to the extent to which these laws contribute to safety and other public interests, and the extent to which such contributions are justified by the cost of the additional manpower. *These disputes will continue to be worked out in the legislatures* and in various forms of collective bargaining between management and the unions.[86]

Ultimately, the Court was unwilling "to invoke the judicial power to invalidate this judgment of the people of Arkansas and their elected representatives as to the price society should pay to promote safety in the railroad industry."[87]

The Third Circuit reached a similar conclusion in 2014, when considering a challenge to a law regulating funeral homes that was enacted in 1952.[88] Among other things, the plaintiffs argued that changes in technology rendered the law's restrictions on food service woefully—and unconstitutionally—outdated. The district court agreed and found that those restrictions violated plaintiffs' due process rights.

But the Third Circuit reversed. In doing so, the court noted that antiquated provisions are "not, however, a constitutional flaw."[89] The court similarly instructed: "It is not up to a court to…*compel legislatures to reexamine restrictions that may seem better suited for an earlier time*…The Constitution is not a lever that we can use to

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86 *Id.* at 143-44 (emphasis added).

87 *Id.* at 144.

88 *Heffner v. Murphy*, 745 F.3d 56, 62 (3d Cir. 2014).

89 *Id.*

overcome legislative inertia."[90]

This is not to say that a law could never be rendered unconstitutional by scientific, economic, or social developments, but merely that a court that is faced with a challenge of this nature should be reluctant to invalidate an originally constitutional law without an adequate showing by the plaintiffs that the law now genuinely imposes a burden on constitutional rights.

C. The licensed physician requirement does not violate the Alaska Constitution.

Although statutes that burden fundamental rights are subject to strict scrutiny, the legal standard still requires the plaintiff to establish that the law is actually a burden on the right: "A party raising a constitutional challenge to a statute bears the burden of *demonstrating the constitutional violation*."[91] And in a case like this, where the plaintiff is making a facial challenge to a statute, it must do more than show that the law "might occasionally create constitutional problems in its application," because this Court must uphold the law "as long as it 'has a plainly legitimate sweep.'"[92]

In its order granting an injunction, this Court expressed skepticism that "Planned Parenthood must quantify the access issues it has identified."[93] But there must still be a minimum quantum of admissible evidence that a plaintiff must produce to show the

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90 *Heffner v. Murphy,* 745 F.3d 56, 86 (3d Cir. 2014) (citing *Heller v. Doe,* 509 U.S. 312, 321 (1993)) (emphasis added).

91 *Planned Parenthood V*, 436 P.3d at 992 (emphasis added) (citing *Andrade*, 23 P.3d at 71).

92 *Planned Parenthood IV*, 375 P.3d at 1133 (citing *Planned Parenthood III*, 171 P.3d at 581).

93 PI Order at 8.

statute does more than "occasionally create constitutional problems in its application." Without that requirement, prior Alaska Supreme Court precedent requiring the plaintiff to show more than occasional problems would be rendered meaningless. It would also turn the presumption of constitutionality on its head.

Here, Planned Parenthood has failed to proffer admissible evidence that the law genuinely burdens access to abortion, instead relying on the simplistic argument that more providers equals more access. But this is only true when the demand for a service exceeds the supply; and just as importantly, it assumes that the law is the but-for cause of the allegedly limited supply.

Planned Parenthood has not established either that the demand for abortion services exceeds the supply *or* that the licensed physician requirement is the reason that supply is limited. Because Planned Parenthood has failed to meet its initial burden to show that the law infringes on a fundamental right, the presumption of constitutionality should stand, and this Court should grant summary judgment to the State.

1. Planned Parenthood has failed to demonstrate that the licensed physician requirement burdens the right to reproductive choice.

Planned Parenthood could establish that the law burdens access to abortion by proffering admissible evidence that the demand for abortion care exceeds the supply and that the law prevents Planned Parenthood from increasing the supply. Or that, as a result of the law, patients more than "occasionally" experience delay in obtaining abortion care that prevents them from obtaining a medication abortion or an abortion of any kind. But Planned Parenthood has no such evidence.

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a. Planned Parenthood's evidence is largely inadmissible hearsay.

At the preliminary injunction stage of this litigation, Planned Parenthood relied on—and this Court accepted[94]—affidavits from two Planned Parenthood employees—Dr. Tanya Pasternack and APRN Amy Bender. However, the critical claims in these affidavits recounting the experiences of their patients are inadmissible hearsay evidence, at best, since the accounts are based on what they were told by their patients.

Worse yet, Dr. Pasternack and APRN Bender's testimony about their patients' experiences is even less reliable than traditional hearsay because neither of them can identify a single declarant who provided the information.[95]

Instead, both witnesses offer impressionistic and self-serving characterizations of their patients' experiences based on what they say some unknown number of unnamed patients have told them over the years. This is the epitome of inadmissible hearsay evidence because it cannot be tested or cross-examined in any meaningful way.

At their depositions, neither witness could provide any specific account of a patient's experience of delay, much less one that was attributable to the licensed physician requirement. Indeed, they could only "speculate" as to the frequency with which patients were delayed either beyond the window for a medication abortion or beyond the period in which abortion was an option.[96] For example, Dr. Pasternack

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94 *See* PI Order citing these affidavits *passim.*

95 Exhibit C, Pasternack Deposition, p. 84 lines 25 – p. 84 line 4, p. 104 line 5 – p. 106 line 19, p. 111 lines 9-14, p. 135 line 17 – p. 136 line 9; Exhibit I, Bender Deposition, p. 67 line 20 – p. 70 line 6, p. 95, line 11 – p. 96 line 5.

96 *See e.g.*, Exhibit I, Bender Deposition, p. 68, lines 7-22, p. 71, lines 4-10.

could only guess that there were "more than on[e] and less than 20".[97] patients who were unable to get an abortion at all because of scheduling delays; she even admitted that testimony was based on what "other providers have told me,".[98] rather than her personal knowledge.

Ms. Bender's and Dr. Pasternack's vague assertions that "some" or "many" of their patients have told them that they've had problems scheduling or were delayed because of an inability to get an appointment are fundamentally unreliable and untestable and are therefore not the sort of evidence a court may rely on to overcome the presumption of constitutionality.[99]

b. The available quantitative evidence does not establish that the licensed physician requirement has created an access problem.

At no point in this litigation has Planned Parenthood relied on any data to make its case. However, it has produced three data sets relating to its abortion services in response to discovery requests. None of this data supports Planned Parenthood's claim that the licensed physician requirement burdens access to abortion in Alaska.

The first data set provides the number of pregnant patients receiving an ultrasound from Planned Parenthood after their pregnancy was at least 11 weeks old, and the number of those patients who received an abortion from Planned Parenthood

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97 Exhibit C, Pasternack Deposition, p. 118, line 8 – p. 120, line 13.

98 Exhibit C, Pasternack Deposition, p. 119, lines 23-25.

99 That is especially true here. Planned Parenthood is the largest, if not the only provider of abortions in Alaska, and it has had decades to gather and compile reliable, admissible evidence of an access problem.

from 2011 through 2020.[100]

But this data set proves nothing because it provides no information about when patients first attempted to schedule an abortion and no information about whether the patient could have obtained an earlier appointment.[101] Indeed, it is not even apparent from the spreadsheet—or any other information provided by Planned Parenthood in response to questions about this data set—that these ultrasounds were necessarily performed on women who were seeking abortion care as opposed to prenatal care. In other words, nothing in the data set establishes that the women who did not receive an abortion from Planned Parenthood actually wanted to get an abortion in the first place, much less that the gestational age shown at ultrasound was the result of a lack of available appointments at Planned Parenthood. The data shows only that some patients had ultrasounds at Planned Parenthood either late in the first trimester or into their second trimester; and that some of that subset of patients had abortions at Planned Parenthood and some did not.

The second data set shows the number of medication and aspiration abortions performed each month at each of Planned Parenthood's four Alaska clinics since 2016.[102] This Court's order granting Planned Parenthood's request for a preliminary injunction created a de facto experiment as to whether the licensed physician requirement imposed a burden on women's access to abortion. Theoretically, if access

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100 *See* Exhibit P.

101 *See also* Exhibit J, Marshall Deposition at p. 73-75.

102 *See* Exhibit O.

to abortion was burdened by the law, one would expect to see an increase in the number of women receiving abortions as a result of the preliminary injunction.

Although at this time the data set remains small, the State's expert evaluated the numbers and found the increase in the number of monthly abortions following the injunction to be so small that it is statistically insignificant.[103] Notably, although the State asked Planned Parenthood to supplement these numbers through trial, Planned Parenthood refused, agreeing only to supplement through the close of discovery.[104] This is doubtless because Planned Parenthood recognizes that this data is unlikely to support its claim that the law caused an access problem.

For example, the Virginia League of Planned Parenthood did not see an overall increase in the number of abortions that it provided in the wake of the repeal of Virginia's licensed physician requirement in 2020.[105] And Dr. Pasternack anticipates that the total number of abortions provided in Alaska in the year after the entry of the

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103 New Affidavit, pp. 5-7, ¶¶ 16-22; *see also* New Report, pp. 3-7.

104 *See* Exhibit L; Exhibit Q.

105 Exhibit M, Ramesh Deposition at p. 33, lines 16-20. The Virginia case is also a good example how a law that is arguably outdated should be dealt with. There, an abortion provider filed a lawsuit to declare the state's physician-only law unconstitutional. After trial, the court ruled in favor of the state, finding that the plaintiff failed to show an undue burden on a significant number of women seeking abortion care. *Falls Church Medical Center, LLC v. Oliver*, 412 F.Supp.3d 668, 691 (E.D. Va. 2019). But the Court went on: "[T]the Court cannot conclude that the Physician-Only law, as it applies to first trimester abortion procedures, is unconstitutional. *Whether it is wise public policy is an issue for the Virginia General Assembly to address*." *Id*. at 692 (emphasis added). After the lawsuit, the legislative process played out, and the law was ultimately repealed by the Virginia General Assembly.

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preliminary injunction in this matter "will be about the same as the year prior."[106]

Planned Parenthood's third data set reflects the average delay between the time a patient calls Planned Parenthood to make an abortion appointment and the time the abortion is performed for each year from 2015 to 2021 and then the average monthly wait time since the injunction was entered.[107] This data set is far from perfect,[108] but it is the data that Planned Parenthood was able to produce. The burden to show a constitutional infringement lies with Planned Parenthood, not with the State, so any inadequacy in this data set must be held against Planned Parenthood rather than the State. And what it shows is no reduction in wait times as a result of this Court's injunction.

To the contrary, the average wait time post-injunction is *higher than* the average annual wait times at three of Planned Parenthood's Alaska clinics.[109] Specifically, for each of the first four months of 2022, the average monthly wait time at the Anchorage facility has been longer than the annual average annual wait time at the Anchorage facility for any of the past six years.[110] Similarly, for the first three months of 2022, the

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106 Exhibit C, Pastenack Deposition at p. 97, lines 20-22.

107 *See* Exhibit N.

108 The data set includes only women who received an abortion at Planned Parenthood and reflects the time between when the abortion appointment was made and when it occurred. It does not include cancellations or missed appointments, Exhibit J, Marshall depo at 53-55, and it does not include information establishing the reason for the delay—i.e. whether the patient chose the first appointment that Planned Parenthood could offer or the first appointment that the patient could make. *See* Exhibit N.

109 Exhibit N; New Affidavit at pp. 3, 9-11 (¶¶ 10, 29-31).

110 Exhibit N; New Affidavit, p. 10 (¶ 30); *see also* New Report, pp. 7-10.

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average monthly wait time at the Fairbanks facility has been longer than the average annual average wait time at the Fairbanks facility for any of the past six years.[111] Finally, each of the first four months of 2022, the average monthly wait time at the Soldotna facility has been longer than the average annual wait time at the Soldotna facility for each of the past 5 years—except 2019.[112]

This data is frankly hard to explain. Likely it reflects the reality that there are many factors that affect when a patient schedules an abortion. But at the very least it offers zero support for Planned Parenthood's contention that appointment availability is a significant cause of delay. The Alaska Supreme Court has directed that courts must "look to the *real-world effects* of government action"[113] when evaluating the burden a statute imposes on constitutional rights. Here, Planned Parenthood has failed to show that there are any real-world effects on patient access to abortion stemming from the statute. As a result, the Court should grant the State's motion for summary judgment.

c. Planned Parenthood has failed to show that it cannot hire more physicians to expand appointment availability.

To establish that the licensed physician requirement burdens abortion access, Planned Parenthood must show that it cannot hire enough physicians to provide the abortions sought by Alaska patients. In granting Planned Parenthood's motion for preliminary injunction, this Court relied in part on Planned Parenthood's representations that it "cannot staff its Alaska clinics with full-time physicians due to the high cost of

111 Exhibit N; New Affidavit, p. 10 (¶ 30); *see also* New Report, pp. 7-10.

112 Exhibit N; New Affidavit, p. 10, (¶ 30); *see also* New Report, pp. 7-10.

113 *Planned Parenthood I*, 28 P.3d at 910.

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OFFICE OF THE ATTORNEY GENERAL
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PHONE: (907) 269-5100

hiring and the difficulty of recruiting them," and that if its APRNs could provide medication abortion, such abortions could be offered on more days a week.[114]

But the evidence shows otherwise. Planned Parenthood currently has eight physicians on per diem rotation and considers itself to be "fully-staffed" with those eight providers.[115] Far from being unable to recruit additional doctors, Planned Parenthood has actually turned away physicians hoping to provide abortion care at Planned Parenthood facilities in Alaska.[116]

Moreover, Planned Parenthood offers aspiration abortions on only one day a week in Anchorage not because of a lack of physicians, but because under its business model, "it's most advantageous and cost effective for the -- for Planned Parenthood Alaska to stack its abortion aspiration procedures to one day a week, or in other locations, once or twice a month."[117]

Dr. Pasternack's testimony further confirms that Planned Parenthood has not increased the number of days that aspiration care is available by choice: "…on other days of the week when we're not providing aspiration, our health center is busy providing a lot of other services, and *we had not desired to change that structure* and offer aspirations by a physician on more than one day a week."[118]

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114 Order Granting Preliminary Injunction at 2.

115 Exhibit C, Pasternack Deposition at p. 138, line 10, p. 143, lines 20-24, p. 159, lines 5-15.

116 Exhibit C, Pasternack Deposition at p. 159, line 2 – p. 164 line 19; and emails.

117 Exhibit C, Pasternack Deposition at p. 163, lines 8-11.

118 Exhibit C, Pasternack Deposition at p. 167, line 25 – p. 68, line 4.

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What's more, under Alaska's telemedicine law, patients do not need to be in the same clinic as the physician in order to receive a medication abortion from that physician.[119] As a result, patients can receive a medication abortion in the Juneau or Fairbanks clinic from a physician who is in Anchorage. And, Planned Parenthood already incorporates this flexibility into its scheduling for abortion care in Alaska.[120]

Additionally, Dr. Pasternack indicated that although "Planned Parenthood operations is complex, … they do consider access for the patients in Fairbanks and Anchorage—or sorry—in Fairbanks and Juneau in their decisions of having their total number of per diem physicians."[121] And, nevertheless, Planned Parenthood considers itself "fully staffed" with its current complement of doctors.[122] This is doubtless because abortion is a simple, safe procedure that typically requires less than twenty minutes of a physician's time[123] and, therefore, a physician can see "somewhere between 20 and 30 patients" on a day that they are providing abortions.[124] And, over the last few years, the number of abortions performed by Planned Parenthood in Alaska each month has ranged from 81-131.[125] Thus, even if each of Planned Parenthood's

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119 *See* AS 08.64.364.

120 Exhibit C, Pasternack Deposition, p. 108, lines 7-22.

121 Exhibit C, Pasternack Deposition at p. 148, lines 12-16.

122 Exhibit C, Pasternack Deposition at p. 159, lines 5-15.

123 Exhibit C, Pasternack Deposition at p. 18, lines 12-16.

124 Exhibit M, Ramesh Deposition at 22, lines 12-16; *see also* Exhibit C, Pasternack Deposition at p. 20, lines 7-8 (estimating 8-12 medication abortions in a four-hour window).

125 Exhibit O.

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ANCHORAGE, ALASKA 99501
PHONE: (907) 269-5100

eight per diem physicians works only one day a month, Planned Parenthood is not close to reaching its capacity to provide abortion services. That Planned Parenthood is perfectly able to meet the demand for abortion care in Alaska even under the licensed physician requirement is also apparent from its recent decision to close its Soldotna clinic,[126] a move that is hardly consistent with an excess of demand.

In sum, the evidence simply does not support Planned Parenthood's claim that it cannot hire enough physicians to meet the need for abortion services in Alaska. Planned Parenthood would doubtless benefit, financially, from a different legal landscape—after all, the monetary savings that it derives from using less highly paid APRNs to provide medication abortion care is not being passed on to patients.[127] But this is an argument it should make to the legislature about why the law should be changed. It is not a constitutional problem.

To the extent Planned Parenthood believes there is unmet demand for abortion services in Alaska, it could hire some full-time physicians. The Virginia League of Planned Parenthood employs three full-time physicians at its clinics;[128] and the evidence before this court does not suggest that Planned Parenthood of Alaska could not do the same thing. Planned Parenthood cannot render this statute unconstitutional by the simple expedient of adhering to a business model that unnecessarily limits its ability to provide abortions consistent with the law.

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126 Exhibit C, Pasternack Deposition at p. 14, lines 18-21.

127 Exhibit C, Pasternack Deposition at p. 125, lines 13-18.

128 Exhibit M, Ramesh Deposition at p. 17, lines 13-15.

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2. Invalidating the licensed physician requirement will not expand abortion access in rural Alaska.

Planned Parenthood devotes considerable space in its complaint to the lack of abortion access in rural Alaska, but it fails to show that this problem is caused by the licensed physician requirement or that it will be alleviated by striking down the law. Planned Parenthood currently operates clinics only in Anchorage, Fairbanks, and Juneau and has offered no evidence of any kind that other health providers in Alaska will begin to offer abortion care if the licensed physician requirement is invalidated.

Moreover, although abortion is a very safe procedure, it is not risk-free and the potential complications are such that abortion patients should typically remain within reach of emergency facilities. As APRN Wendy Monrad explained in her affidavit in support of the State's preliminary injunction opposition, the standard of practice for APRNs requires that:

> prior to administering treatment with known, potentially serious complications, the APRN must have in place a plan to respond to such complications should they occur. [And w]here a potential complication is excessive bleeding, the treatment plan must include a reasonably practical way to transport the patient timely to a hospital or other facility where appropriate resources are readily available to address the patient's condition.[129]

And Ms. Bender confirmed this in her deposition, explaining that her pre-

[129] Affidavit of Wendy Monrad at ¶¶ 5-6. Ms. Monrad further stated: "It has been my experience that in the few areas off the road system that are served by hospital facilities, transportation to those facilities is limited and often not reasonably practical, and certainly not predictable enough to be part of a treatment plan that is consistent with what the standard of practice requires of an APRN administering treatment with known, potentially serious complications." *Id*. at ¶ 7.

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abortion counseling includes discussion of the patient's access to "emergent services in the instance that they would need them."[130]

Thus, any action this court takes with respect to the licensed physician requirement is not going to change the reality of health care access in rural Alaska. Rural abortion patients will still need to travel to urban centers to obtain abortion care just as they have to travel to obtain most specialized health care.

3. The licensed physician requirement does not violate the equal protection rights of patients or advanced practice clinicians.

i. For equal protection purposes, classification is defined by the terms of the statute at issue.

The Alaska's Constitution's equal protection clause provides that "all persons are equal and entitled to equal rights, opportunities, and protection under the law."[131] The Alaska Supreme Court has interpreted the equal protection clause "to be a 'command to state and local governments to treat those who are *similarly situated* alike.'"[132]

The first step in an equal protection analysis is to decide which classes must be compared.[133] That step has been referred to as "classification."[134] Only after classification can the court move to the next step of determining whether the statute

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130 Exhibit I, Bender Deposition at p. 42, lines 5-6.

131 ALASKA CONST. art. I, § 1. As a general rule, duly enacted laws are presumed to be constitutional. Courts should construe enactments to avoid a finding of unconstitutionality to the extent possible. *Treacy v. Municipality of Anchorage*, 91 P.3d 252, 260 (Alaska 2004).

132 *Pub. Emps.' Ret. Sys. v. Gallant*, 153 P.3d 346, 349 (Alaska 2007) (emphasis added) (quoting *Gonzales v. Safeway Stores, Inc.*, 882 P.2d 389, 396 (Alaska 1994)).

133 *Watson v. State*, 487 P.3d 568, 570 (Alaska 2021).

134 *Id*.

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discriminates between two similarly situated classes by treating them differently.[135]

In *Watson v. State*, the Alaska Supreme Court "emphasized" that "a classification is defined *by the terms of the statute at issue*."[136] There, the court evaluated an exception to a general rule that minors who violate criminal laws are subject to the jurisdiction of juvenile court. The exception applied to minors accused of traffic violations, who were charged as adults, but it did not apply when the minor was accused of a felony.

Applying the plain terms of the statutes, the court concluded: "Taken together, these statutes create two classes: minors charged with felony traffic offenses, who are charged as juveniles, and those charged with non-felony traffic offenses, who are charged as adults."[137] The court rejected a narrower classification put forth by the accused minor:

> Watson suggests that we focus only on minors accused of non-felony DUI, and compare them either to minors accused of most other offenses or minors accused of felony DUI. But this classification would be too narrow. As the United States Supreme Court has explained, "*the validity of a broad legislative classification is not properly judged by focusing solely on the portion of the disfavored class that is affected most harshly by its terms*."[138]

The Court applied the "same reasoning" to Watson's claim: "We should not evaluate the constitutionality of a statute impacting all juvenile traffic offenders by

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135 *Id.*

136 *Id.* at 571.

137 *Id.*

138 *Id.* (quoting *Schweiker v. Hogan*, 457 U.S. 569, 589 (1982)) (emphasis added).

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considering only the treatment of those charged with a DUI. We therefore consider the two statutorily defined classes of minors charged with non-felony traffic offenses and minors charged with felony traffic offenses."[139]

In short, the court should focus on the plain terms of the statute at issue in determining the proper classifications. Focusing solely on the portion of the disfavored class most severely impacted by the statute is improper.

ii. The classifications put forth by Planned Parenthood fail as a matter of law.

Here, Planned Parenthood argues that the statute creates two classifications; (1) physicians and APCs; and (2) pregnant women seeking to end viable pregnancies via mifepristone/misoprostol and pregnant women seeking miscarriage treatment via mifepristone/misoprostol. Both proffered classifications fail as a matter of law.

Alaska Statute 18.16.010 provides: "An abortion may not be performed in this state unless the abortion is performed by a physician licensed by the State Medical Board under AS 08.64.200…".[140] Thus, the plain terms of the statute create two classifications: physicians licensed by the State Medical Board and individuals who are *not* physicians licensed by the State Medical Board.

Planned Parenthood's argument that that statute treats APCs differently than licensed physicians fails as a matter of law because it "focus[es] solely on the portion of

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139 *Id.*

140 *Id.*

the disfavored class that is affected most harshly by its terms."[141] Contrary to Planned Parenthood's characterization, the law is not an "APC ban." It prohibits anyone who is not a licensed physician from performing an abortion.

Planned Parenthood's argument that the statute treats women seeking abortion care differently than women seeking miscarriage care likewise fails as a matter of law because it bears no relationship whatsoever to the classification created by the statute – licensed physicians vs. non-licensed physicians. Accordingly, Plaintiff's equal protection claim should be dismissed.

V. CONCLUSION

Because Planned Parenthood has not met its burden to establish that the licensed physician requirement burdens access to abortion care in Alaska, this Court should grant the State's motion for summary judgment and dismiss the complaint.

DATED August 1, 2022.

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141 *See id.*