

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

PLANNED PARENTHOOD GREAT  
NORTHWEST, HAWAI'I, ALASKA,  
INDIANA, KENTUCKY, a Washington  
corporation,

Plaintiff,

v.

STATE OF ALASKA, et al.,

Defendants.

Case No. 3AN-19-11710 CI

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**PLAINTIFF'S OPPOSITION TO**  
**DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

## TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES.....	ii
I. Introduction .....	1
II. The Motion Should Be Denied Because the APC Ban Currently Infringes on the Right to Abortion.....	2
III. The Motion Should Be Denied Because the APC Ban Is Subject to Strict Scrutiny .....	7
A. In Framing Its Equal Protection Claim, Plaintiff Has Identified Valid Classifications Created by the APC Ban.....	7
B. The State Misstates Plaintiff’s Evidentiary Burden to Challenge the Constitutionality of the APC Ban .....	11
C. Plaintiff Has Presented Ample Admissible Evidence That the APC Ban Burdens the Right to Abortion Such That It Is Subject to Strict Scrutiny .....	13
D. The State Cannot Overcome Plaintiff’s Evidence That the APC Ban Burdens Abortion Access.....	18
1. Plaintiff’s Evidence Is Admissible.....	19
2. The State’s Attempt to Rebut Plaintiff’s Evidence Fails .....	25
E. It Is Legally Immaterial Whether There Are Other Obstacles, Alongside the APC Ban, to the Provision and Obtainment of Abortion Care .....	28
IV. CONCLUSION .....	34

## TABLE OF AUTHORITIES

	Page
<b>Cases</b>	
<i>Alaska Civ. Liberties Union v. State</i> , 122 P.3d 781 (Alaska 2005) .....	6
<i>Armstrong v. State</i> , 989 P.2d 364 (Mont. 1999) .....	3
<i>Bhd. of Locomotive Firemen &amp; Enginemen v. Chi., Rock Island &amp; Pac. R.R. Co.</i> , 393 U.S. 129 (1968) .....	5
<i>Brown v. Buhman</i> , 947 F. Supp. 2d 1170 (D. Utah 2013, <i>vacated on other grounds</i> , 822 F.3d 1151 (10th Cir. 2016) .....	3, 4
<i>Buntin v. Schlumberger Tech. Corp.</i> , 487 P.3d 595 (Alaska 2021) .....	26
<i>Carpenter v. United States</i> , 138 S. Ct. 2206 (2018) .....	4
<i>Connecticut v. Menillo</i> , 423 U.S. 9 (1975) .....	7
<i>De Leon v. Perry</i> , 975 F. Supp. 2d 632 (W.D. Tex. 2014) .....	4
<i>Heffner v. Murphy</i> , 745 F.3d 56 (3d Cir. 2014) .....	5
<i>Hodgson v. Minnesota</i> , 648 F. Supp. 756 (D. Minn. 1986), <i>rev'd</i> , 853 F.2d 1452 (8th Cir. 1988) .....	22
<i>Kermani v. N.Y. State Bd. of Elections</i> , 487 F. Supp. 2d 101 (N.D.N.Y. 2006) .....	3, 4
<i>Mazurek v. Armstrong</i> , 520 U.S. 968 (1997) .....	7
<i>Memphis Planned Parenthood, Inc. v. Sundquist</i> , 2 F. Supp. 2d 997 (M.D. Tenn. 1997), <i>rev'd</i> , 175 F.3d 456 (6th Cir. 1999) .....	22

**TABLE OF AUTHORITIES**  
(continued)

	<b>Page</b>
<i>Merriman v. Berryhill</i> , No. 16-CV-50073, 2017 WL 2345551 (N.D. Ill. May 30, 2017).....	23
<i>Obergefell v. Hodges</i> , 576 U.S. 644 (2015) .....	3
<i>Planned Parenthood of Alaska v. State</i> , No. 3AN-97-6014, 2003 WL 25446126 (Alaska Super. Ct. Oct. 13, 2003), <i>aff'd</i> , 171 P.3d 577 (Alaska 2007).....	12, 22
<i>Planned Parenthood Ariz., Inc. v. Humble</i> , 753 F.3d 905 (9th Cir. 2014) .....	30
<i>Planned Parenthood Ass'n of Atlanta Area, Inc. v. Harris</i> , 670 F. Supp. 971 (N.D. Ga. 1987).....	22
<i>Planned Parenthood of the Great Nw. v. State</i> , 375 P.3d 1122 (Alaska 2016) .....	passim
<i>Planned Parenthood of the Great Nw. v. State</i> , No. 3AN-10-12279, 2012 WL 4835506.....	13, 14, 29, 31
<i>Planned Parenthood of the Great Nw. v. Streur</i> , No. 3AN-14-04711, 2015 WL 9898581 (Alaska Super. Ct. Aug. 27, 2015), <i>aff'd sub nom. State v. Planned Parenthood of the Great Nw.</i> , 436 P.3d 984 (Alaska 2019) .....	passim
<i>Planned Parenthood of Ind. &amp; Ky., Inc. v. Comm'r of Ind. State Dep't of Health</i> , 896 F.3d 809 (7th Cir. 2018), <i>vacated and remanded on other grounds sub nom. Box v. Planned Parenthood of Ind. &amp; Ky., Inc.</i> , 141 S. Ct. 184 (2020).....	30
<i>Roe v. Wade</i> , 410 U.S. 113 (1973).....	7
<i>Sluka v. State</i> , 717 P.2d 394 (Alaska Ct. App. 1986).....	21
<i>South Dakota v. Wayfair, Inc.</i> , 138 S. Ct. 2080 (2018).....	4, 5

**TABLE OF AUTHORITIES**  
(continued)

	<b>Page</b>
<i>State v. Alaska Democratic Party</i> , 426 P.3d 901 (Alaska 2018) .....	3
<i>State v. Erickson</i> , 574 P.2d 1 (Alaska 1978) .....	13
<i>State v. Galvin</i> , No. S-17887, 2021 WL 2879321 (Alaska July 9, 2021) .....	3
<i>State v. Ostrosky</i> , 667 P.2d 1184 (Alaska 1983) .....	13
<i>State v. Planned Parenthood of Alaska</i> , 171 P.3d 577 (Alaska 2007) .....	5, 6, 7
<i>State v. Planned Parenthood of Alaska</i> , 35 P.3d 30 (Alaska 2001) .....	5
<i>State v. Planned Parenthood of the Great Nw.</i> , 436 P.3d 984 (Alaska 2019) .....	passim
<i>State v. Santiago</i> , 122 A.3d 1 (Conn. 2015) .....	4
<i>State v. Schmidt</i> , 323 P.3d 647 (Alaska 2014) .....	6
<i>State, Dep't of Health &amp; Soc. Servs. v. Planned Parenthood of Alaska, Inc.</i> , 28 P.3d 904 (Alaska 2001) .....	10, 12, 13, 29
<i>Treacy v. Mun. of Anchorage</i> , 91 P.3d 252 (Alaska 2004) .....	13
<i>United States v. Sanchez-Lima</i> , 161 F.3d 545 (9th Cir. 1998) .....	21
<i>Valley Hosp. Ass'n v. Mat-Su Coal. for Choice</i> , 948 P.2d 963 (Alaska 1997) .....	13, 30
<i>Watson v. State</i> , 487 P.3d 568 (Alaska 2021) .....	9, 11

**TABLE OF AUTHORITIES**  
(continued)

**Page**

*Weems v. State*,  
No. ADV-2018-73 (Mont. Dist. Ct. Feb. 25, 2022) ..... 3

**Rules**

Alaska R. Evid. 703 ..... 21  
Alaska R. Evid. 803(1)–(4) ..... 21  
Alaska R. Evid. 803(23) ..... 21

**Regulations**

12 AAC 40.400 ..... 9  
12 AAC 40.430 ..... 9  
12 AAC 44.400 ..... 9  
12 AAC 44.430 ..... 9

**Constitutional Provisions**

Alaska Constitution ..... 7

**Other Authorities**

Alaska Dep’t of Health, Report of Induced Termination of Pregnancy (July  
2022) ..... 25

## I. Introduction

As the State all but admits in its summary judgment motion, the APC Ban<sup>1</sup> challenged here serves no valid purpose, let alone a compelling state interest. As such, the APC Ban cannot possibly satisfy strict scrutiny. Faced with this reality, the State offers a series of strained arguments for avoiding constitutional review. The State's arguments fail and, as a result, Plaintiff's claims survive and the State's Motion for Summary Judgment should be denied.

The State suggests that, regardless of the APC Ban's current (and indeed longstanding) effects, it cannot be unconstitutional because it was not originally intended to restrict access when enacted in 1970. But this Court already correctly held in its order granting the preliminary injunction (the "PI Order") that a restriction infringes on constitutional rights if its current "real-world *effects*" constrain the exercise of those rights. PI Order at 9 (emphasis added and quotation marks omitted). The State trivializes Plaintiff's evidence of the Ban's effects, arguing that Planned Parenthood must precisely quantify these effects for them to be legally significant. That is contrary to the PI Order and controlling Alaska precedent. Further, the State's arguments wholly ignore that, in enforcing the equal protection clause, courts focus not on the *degree* of burden imposed by a challenged restriction, but on whether a *classification* that restriction creates is *based on*

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<sup>1</sup> Planned Parenthood uses the term "APC Ban" to include AS 18.16.010 as well as the Alaska State Board of Nursing's restriction of advanced practice clinicians' ("APCs") performing aspiration for miscarriage and incomplete abortion. Unless otherwise identified as supplemental affidavits, factual citations are to affidavits filed in support of Plaintiff's Motion for Summary Judgment ("Mot.").

the exercise of a fundamental right. Nor do the State’s arguments fare better with respect to Plaintiff’s privacy claim, which simply requires a showing of infringement, not a quantification of specific further harms.

Finally, the State attempts to characterize the problem of limited abortion access in Alaska as part of the general “tyranny of distance” and/or Plaintiff’s own fault. State Defs’ Mot. for Summ. J. (“Def. Br.”) at 4. The State’s argument is wholly irrelevant to Plaintiff’s equal protection claim, and as for its privacy claim, the only relevant inquiry is whether the APC Ban needlessly *compounds* barriers to care that exist in the “real world” of a rural state geography and limited provider resources. Notwithstanding the State’s deflection, Plaintiff has admissible evidence that the APC Ban does so. And, since the State has not even attempted to show that the APC Ban is the least restrictive means of serving a compelling state interest, its summary judgment motion must fail.<sup>2</sup>

**II. The Motion Should Be Denied Because the APC Ban Currently Infringes on the Right to Abortion.**

While conceding that laws can sometimes “be rendered unconstitutional by scientific, economic, or social developments,” the State asserts that courts “should be reluctant to invalidate an originally constitutional law.” Def. Br. at 25. In fact, courts have not hesitated to invalidate even longstanding laws, including ones that may once have been constitutional, based on their current, unconstitutional effects.

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<sup>2</sup> Plaintiff’s Motion for Summary Judgment sets out why the APC Ban fails strict scrutiny as a matter of law. Mot. at 19–25.

For example, the Alaska Supreme Court in 2018 held unconstitutional the State’s longstanding rule requiring a candidate to register as a member of a political party before running in that party’s primary election. *State v. Alaska Democratic Party*, 426 P.3d 901, 914–15 (Alaska 2018); *State v. Galvin*, No. S-17887, 2021 WL 2879321, at \*1–2 (Alaska July 9, 2021) (noting the Alaska Supreme Court’s holding in *Alaska Democratic Party* that the “long-standing ‘party affiliation rule,’” enacted in 1980, “violated the Alaska Democratic Party’s right to free political association”).

Courts in other jurisdictions agree and routinely hold state laws unconstitutional long after their enactment. Indeed, a Montana court recently struck down a longstanding restriction on APC provision of abortion care similar to Alaska’s. Order—Mots. Summ. J., *Weems v. State*, No. ADV-2018-73 (Mont. Dist. Ct. Feb. 25, 2022).<sup>3</sup> And courts have invalidated longstanding laws in a range of other areas. *See, e.g., Kermani v. N.Y. State Bd. of Elections*, 487 F. Supp. 2d 101, 117 (N.D.N.Y. 2006) (declaring unconstitutional New York campaign finance law, enforced since the early 1900s); *Brown v. Buhman*, 947 F. Supp. 2d 1170, 1234 (D. Utah 2013) (invalidating Utah criminal law, enforced since 1973, making it a crime to “purport[] to marry” more than one person or to cohabit with someone other than a spouse), *vacated on other grounds*, 822 F.3d 1151 (10th Cir. 2016); *Obergefell v. Hodges*, 576 U.S. 644 (2015) (invalidating laws in various states passed since 1741).

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<sup>3</sup> An earlier version of Montana’s APC Ban, enacted in the 1970s, was challenged in the 1990s and permanently enjoined. *See Armstrong v. State*, 989 P.2d 364, 371 (Mont. 1999).

Sometimes courts invalidate older state laws because the passage of time and the corresponding progress of science, technology, or other laws alter the facts in a way that renders the previously-constitutional law presently unconstitutional. *See, e.g., Kermani*, 487 F. Supp. 2d at 103, 110 (holding that limits on election contributions for uncoordinated individuals were no longer constitutional because “it is much less likely that present-day Parties would have a totalitarian ‘boss’ like William Tweed” and “there is no ground for relying on prior historical justifications based upon the goal of fighting corruption”); *Carpenter v. United States*, 138 S. Ct. 2206, 2221–23 (2018) (declaring unconstitutional provision of 1983 statute because “the progress of science has afforded law enforcement a powerful new tool” susceptible to abuse); *South Dakota v. Wayfair, Inc.*, 138 S. Ct. 2080, 2095 (2018) (holding, contrary to precedent, that state could tax out-of-state online retailers because of “[t]he dramatic technological and social changes of our increasingly interconnected economy” (internal quotation marks and citation omitted)).

Other times, it is societal norms that have changed. *See, e.g., Buhman*, 947 F. Supp. 2d at 1210, 1234 (invalidating a Utah statute criminalizing cohabitation of a married person with someone other than their spouse, including because such cohabitation has become “commonplace”); *De Leon v. Perry*, 975 F. Supp. 2d 632, 647 (W.D. Tex. 2014) (holding that “subsequent doctrinal and societal developments since 1972 compel this Court to conclude that . . . the issue of same-sex marriage now presents a substantial federal question”); *State v. Santiago*, 122 A.3d 1, 55 (Conn. 2015) (holding that “Connecticut’s capital punishment scheme no longer comports with our state’s contemporary standards of decency,” based on legislative findings, precedent from other states, and the opinions of

professional associations). Regardless of the nature of the change in underlying facts or circumstances, none of these opinions considered the age of a statute or the fact that it may have been lawful when it was enacted relevant to its constitutionality. Likewise “[t]his Court should not maintain a rule that ignores” the present day circumstances that have rendered the APC Ban unconstitutional. *Wayfair, Inc.*, 138 S. Ct. at 2095.<sup>4</sup>

The State relies on two federal cases to argue that courts should not second-guess state legislative decisions, “even [those] undertaken decades earlier.” Def. Br. at 24. But in neither case was a fundamental right at stake. *See Bhd. of Locomotive Firemen & Enginemen v. Chi., Rock Island & Pac. R.R. Co.*, 393 U.S. 129, 143 (1968) (applying rational basis review to due process claim that staffing requirements imposed unnecessary costs); *Heffner v. Murphy*, 745 F.3d 56, 79–88 (3d Cir. 2014) (applying rational basis review to state health and safety limitation on food service at funeral homes). Rather, both of these cases stand for the uncontroversial and irrelevant principle that when fundamental rights are *not* at stake, courts should not second-guess the legislature’s public policy judgments. By contrast, in reviewing abortion restrictions, Alaska courts exercise “independent judgment,” “assess[ing] the nature and importance of the competing personal and governmental interests at stake, identify[ing] the relevant level of scrutiny for

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<sup>4</sup> The State faults Plaintiff for not lobbying for legal reform. Def. Br. at 2. But courts, not the political branches, safeguard fundamental rights. At any rate, since at least 1997, far from entertaining proposals to improve abortion access, the State has relentlessly tried to *restrict* it. *See, e.g., State v. Planned Parenthood of Alaska*, 35 P.3d 30 (Alaska 2001); *State v. Planned Parenthood of Alaska*, 171 P.3d 577 (Alaska 2007); *Planned Parenthood of the Great Nw. v. State*, 375 P.3d 1122 (Alaska 2016); *State v. Planned Parenthood of the Great Nw.*, 436 P.3d 984 (Alaska 2019).

governmental action, and assess[ing] the means chosen to advance governmental interests.” *State v. Planned Parenthood of the Great Nw.* (*Planned Parenthood 2019*), 436 P.3d 984, 991 (Alaska 2019) (alterations in original) (quoting *Planned Parenthood of the Great Nw. v. State* (*Planned Parenthood 2016*), 375 P.3d 1122, 1132 (Alaska 2016)).

The State also suggests that the APC Ban passes constitutional muster because it was not originally “*intended to limit or restrict a women’s [sic] right to abortion care.*” Def. Br. at 2 (emphasis added). But Plaintiff need not show discriminatory intent to prevail on its constitutional claims. To succeed on an equal protection claim, a plaintiff “must show *either* that facially neutral state action has a discriminatory purpose *or* that the state action is facially discriminatory. When a ‘law by its own terms classifies persons for different treatment,’ the law is facially discriminatory.” *State v. Schmidt*, 323 P.3d 647, 659 (Alaska 2014) (emphasis added) (quoting *Alaska Civ. Liberties Union v. State*, 122 P.3d 781, 788 (Alaska 2005)). Here (as explained below), the APC Ban classifies and treats pregnant patients seeking abortions differently from pregnant patients not seeking abortions. Lack of discriminatory intent is thus irrelevant for Plaintiff’s equal protection claim. It is also irrelevant to Plaintiff’s substantive due process claim. *See State v. Planned Parenthood of Alaska* (*Planned Parenthood 2007*), 171 P.3d 577, 579, 582 (Alaska 2007) (in invalidating parental consent requirement, taking at face value the State’s “undeniably compelling interest in protecting the health of minors and in fostering family involvement in a minor’s

decisions regarding her pregnancy,” but finding that the requirement impermissibly “places a burden on minors’ fundamental right to privacy”).<sup>5</sup>

### **III. The Motion Should Be Denied Because the APC Ban Is Subject to Strict Scrutiny.**

The State concedes that under well-established Alaska precedent, laws are subject to strict scrutiny under the due process clause of the Alaska Constitution if they infringe on a fundamental right, and under the equal protection clause of the Alaska Constitution if they distinguish between similarly situated groups based on the exercise of a fundamental right. *See* Def. Br. at 25; *Planned Parenthood 2007*, 171 P.3d at 582–85; *Planned Parenthood 2016*, 375 P.3d at 1139–43; *Planned Parenthood 2019*, 436 P.3d at 1004. The State tries to circumvent the strict scrutiny test, however, by arguing (1) that Plaintiff has failed to frame proper classes for its equal protection claim; and (2) that to make any of its claims, Plaintiff must *quantify* how many Alaskans are burdened and/or *identify* individual Alaskans burdened by the APC Ban, and that Plaintiff has failed to do so. These arguments mischaracterize both the applicable law and the factual record.

#### **A. In Framing Its Equal Protection Claim, Plaintiff Has Identified Valid Classifications Created by the APC Ban.**

When Alaska courts consider abortion restrictions under the equal protection framework, the threshold question they ask is whether the State treats two similarly situated

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<sup>5</sup> The State also quotes federal case law approving of physician-only laws. Def. Br. at 20 n.71. These cases are irrelevant; among other reasons, they were decided well before the medical advances and standardization of the APC profession that have made the APC Ban wholly obsolete and unjustified. *See Roe v. Wade*, 410 U.S. 113 (1973); *Connecticut v. Menillo*, 423 U.S. 9 (1975); *Mazurek v. Armstrong*, 520 U.S. 968 (1997) (upholding a physician-only law against the claim that it was enacted with a discriminatory purpose).

classes “unequally” with respect to their decision-making around abortion, and *not* how *much* that unequal treatment impedes access to abortion. *Planned Parenthood 2016*, 375 P.3d at 1135 (invalidating parental notice law under equal protection clause without considering level of burden this law imposed on minors); *see also Planned Parenthood 2019*, 436 P.3d at 1000. As this Court held in its PI Order with respect to medication abortion:

AS 18.16.010, as applied to the provision of medication abortion by APCs, results in different treatment for two groups of people: pregnant patients seeking abortions and pregnant patients not seeking abortions but experiencing miscarriage. The statute dictates a patient’s access to care based on their decision to obtain an abortion; it prevents patients seeking abortions from receiving care—a combination regimen of mifepristone and misoprostol—that APCs can and do provide to patients experiencing miscarriage.

PI Order at 9–10. The same reasoning holds true for aspiration; the State bars abortion patients from receiving this care from APCs while allowing miscarriage patients to receive medically identical care from them.<sup>6</sup> Because abortion is a fundamental right, this unequal

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<sup>6</sup> The State’s treatment of miscarriage aspiration has been inconsistent, but at any rate is more permissive than its treatment of aspiration abortion. In a January 9, 2006, Advisory Opinion, the Alaska State Board of Nursing (“BON”) approved the request of an individual Advanced Practice Registered Nurse (“APRN”) employed by Planned Parenthood to confirm that her scope of practice included providing uterine aspiration procedures for patients with a non-viable pregnancy, incomplete spontaneous abortion (miscarriage), or complicated procedural or medical abortion (where pregnancy is non-viable). *See Power Aff. Ex. F (BON Letter); Ex. G (Advisory Opinion excerpt); Ex. A (Monrad Dep.) 82:3–15.* The BON subsequently denied a similar application, but recently stated that APCs can provide this care as long as it is consistent with their scope as outlined by national medical bodies. *Id. Ex. A (Monrad Dep.) 91:13–92:5.*

treatment triggers strict scrutiny. *Id.* at 10.<sup>7</sup>

The State argues that Plaintiff’s framing of two classes—pregnant women seeking to end viable pregnancies and pregnant women seeking miscarriage treatment—fails as a matter of law because the plain terms of the statute do not explicitly distinguish between these classes. Def. Br. at 39–40.<sup>8</sup> But the State’s position fails to consider all the relevant statutes “[t]aken together” in identifying the classification created, as required under the State’s own authority. *Watson v. State*, 487 P.3d 568, 571 (Alaska 2021). Applying *Watson*, the APC Ban should be read alongside Alaska statutes and regulations that authorize APCs to provide medical care generally, including for miscarriage management and obstetrics. *See* 12 AAC 44.400 (enacted 1980, last amended 2022) (licensing requirements for APRNs); 12 AAC 44.430 (APRN scope of practice); 12 AAC 40.400 (licensing requirements for physician assistants); 12 AAC 40.430 (physician assistant scope of practice); *cf. Planned Parenthood of the Great Nw. v. Streur*, No. 3AN-14-04711, 2015 WL 9898581, at \*17 (Alaska Super. Ct. Aug. 27, 2015) (comparing Medicaid program’s

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<sup>7</sup> Courts have already determined that Alaskans seeking an abortion are similarly situated to those continuing their pregnancy with respect to medical risk. *Planned Parenthood 2016*, 375 P.3d at 1135, 1141–42 (finding no health justification for treating two groups differently). Here too, the State does not dispute that Alaskans seeking an abortion are similarly situated to those continuing their pregnancy for purposes of state laws ensuring that only qualified medical providers may offer medical care. Undisputed record evidence establishes that these two groups are similarly situated with respect to the clinical skills required for treatment. *See* Ramesh Aff. ¶¶ 29–30, 36–38, 45–50, 60–62; Pasternack Aff. ¶¶ 10–16, 18; Bender Aff. ¶¶ 6–9, 12, 18–19; Spetz Aff. ¶¶ 9, 11–15, 69.

<sup>8</sup> References to “women” in Plaintiff’s submissions are shorthand for people who are or may become pregnant. People with other gender identities, including transgender men and gender-diverse individuals, may also become pregnant and seek abortion care.

treatment of abortion to other health services, including pregnancy; “[t]he court is aware of no other context where Medicaid engages in such a relentlessly one-sided calculus”), *aff’d sub nom. State v. Planned Parenthood of the Great Nw.*, 436 P.3d 984 (Alaska 2019).

Nor is the State’s argument consistent with Alaska abortion-related precedent. In *Planned Parenthood 2016*, for example, the plain terms of the parental notification statute at issue regulated abortion for minors but did not explicitly address minors seeking to carry to term. Nonetheless, the Supreme Court recognized the distinction it created, finding that the “relevant classes are pregnant minors seeking termination and pregnant minors seeking to carry to term.” *Planned Parenthood 2016*, 375 P.3d at 1135; *see also Planned Parenthood 2019*, 436 P.3d at 1001 (concluding that for statute limiting Medicaid coverage of abortions, “[t]he most appropriate comparison classes are . . . Medicaid-eligible women who seek funding for abortion and Medicaid-eligible women who seek funding for natal and prenatal care”); *State, Dep’t of Health & Soc. Servs. v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904, 913 (Alaska 2001) (“[A] woman who carries her pregnancy to term and a woman who terminates her pregnancy exercise the same fundamental right to reproductive choice. Alaska’s equal protection clause does not permit governmental discrimination against either woman.”). Similarly, the APC Ban, read together with Alaska laws regulating APCs, allows patients to obtain miscarriage, prenatal, and obstetrics care from APCs, but not abortion care.<sup>9</sup>

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<sup>9</sup> Plaintiff’s equal protection claim also separately challenges the APC Ban’s differential treatment of APCs and physicians. Compl. ¶ 118. The Court did not rely on this classification for its PI Order, and it need not consider it here given the other  
(continued . . .)

For these reasons, Plaintiff has framed proper classifications, consistent with precedent, that clearly reflect discrimination based on the exercise of a fundamental right.

**B. The State Misstates Plaintiff's Evidentiary Burden to Challenge the Constitutionality of the APC Ban.**

The State's motion rests in large part on a misplaced notion that to prove its claims, Plaintiff must specifically quantify the harm the APC Ban has caused patients or identify specific Alaskans whose rights are being infringed by the APC Ban from obtaining care. That is not the law. *See* PI Order at 8 (rejecting State's argument that Plaintiff must quantify access issues). The Alaska Supreme Court has repeatedly invalidated abortion restrictions, based on both due process and equal protection analyses, without specifically quantifying the harm caused by challenged restrictions or identifying specific Alaskans burdened.

Not only do the State's claims find no express support in the case law, but it would be inconsistent with the approach the Alaska Supreme Court *has* taken in challenges to abortion restrictions. Rather, strict scrutiny has been applied once plaintiffs demonstrate that a restriction burdens a fundamental right. As this Court previously found in the context of medication abortion (but the same reasoning applies to aspiration), Plaintiff has satisfied this step by showing that the APC Ban "dictates a patient's access to care based on their decision to obtain an abortion; it prevents patients seeking abortions from receiving care—

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impermissible classifications the Ban creates. At any rate, just as the *Watson* court read multiple statutes together to determine the scope of the classifications at issue, here too, the APC Ban, read alongside other provisions of law that authorize APCs to provide medically comparable care, clearly discriminates between physicians and other qualified and licensed medical professionals, *i.e.*, APCs. Clinicians at a lower level of licensure and unlicensed individuals are simply not at issue because they would not be authorized to provide this care even absent the APC Ban.

a combination regimen of mifepristone and misoprostol—that APCs can and do provide to patients experiencing miscarriage.” PI Order at 9–10. This reasoning is in line with years of consistent precedent.

For example, in *Planned Parenthood 2019*, the court invalidated an Alaska Medicaid provision limiting funding for abortion under the state equal protection clause, after finding that the provision “burden[ed]” the right to abortion. 436 P.3d at 1001. The court did not cite any quantitative findings, nor did it identify individual patients burdened by the provision, but rather considered the general “real-world” “deter[rent]” effects of withholding safety-net insurance coverage for abortion. *See id.* at 1001–03 (quoting *State, Dep’t of Health & Soc. Servs.*, 28 P.3d at 909–11). Similarly, this Court has repeatedly struck down parental involvement laws without requiring quantification or identification of patients who are burdened, and based in part on provider testimony. *Planned Parenthood of Alaska v. State*, No. 3AN-97-6014, 2003 WL 25446126, ¶¶ 78–86 (Alaska Super. Ct. Oct. 13, 2003) (relying on physician testimony regarding common burdens for minors seeking judicial bypass of parental consent requirement), *aff’d*, 171 P.3d 577 (Alaska 2007). And the court has recognized that a right can be burdened even when it is not entirely barred. For example, in *Planned Parenthood 2016*, the Alaska Supreme Court considered it self-evident that the burden of simply requiring minors to notify their parents (or seek judicial leave) was sufficient to trigger strict scrutiny review. 375 P.3d at 1136.<sup>10</sup> Finally,

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<sup>10</sup> The district court decision in this case analyzed the notice law under the due process clause. Although it ultimately ruled for Defendants, it found that the restriction was an infringement triggering strict scrutiny, based solely on a finding in passing that the  
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the court did not hesitate to find that a single state hospital’s refusal to provide abortion was a sufficient “interfer[ence]” in fundamental rights to trigger strict scrutiny, regardless of whether Alaskans could travel elsewhere for care. *Valley Hosp. Ass’n v. Mat-Su Coal. for Choice*, 948 P.2d 963, 971 (Alaska 1997).

None of these cases required a specific quantum of burden, nor is this required in other equal protection or due process case law. *See, e.g., Treacy v. Mun. of Anchorage*, 91 P.3d 252, 265 (Alaska 2004) (agreeing with plaintiff that “because fundamental rights are implicated, strict scrutiny is the appropriate level of review” (emphasis added)); *State, Dep’t of Health & Soc. Servs.*, 28 P.3d at 909 (“[Strict] scrutiny is appropriate where a challenged enactment affects ‘fundamental rights.’” (emphasis added) (quoting *State v. Ostrosky*, 667 P.2d 1184, 1192 (Alaska 1983))); *cf. Ostrosky*, 667 P.2d at 1193 (explaining that the level of scrutiny depends “‘upon the importance of the rights involved’” (emphasis added) (quoting *State v. Erickson*, 574 P.2d 1, 11–12 (Alaska 1978))).

Ultimately, given this clear body of precedent, the State’s quibbles with Plaintiff’s supposed lack of evidence are meritless.

**C. Plaintiff Has Presented Ample Admissible Evidence That the APC Ban Burdens the Right to Abortion Such That It Is Subject to Strict Scrutiny.**

Not only does the State mischaracterize the nature of Plaintiff’s evidentiary burden, but it then makes a straw man of Plaintiff’s evidence, characterizing it as “vague, impressionistic and effectively untestable.” Def. Br. at 1–2. To the contrary, Plaintiff has

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parental notice law “may delay a minor’s abortion.” *Planned Parenthood of the Great Nw. v. State*, No. 3AN-10-12279, 2012 WL 4835506, at § II(d) (Alaska Super. Ct. Oct. 8, 2012), *partially rev’d on other grounds*, 375 P.3d 1122 (Alaska 2016).

clear, admissible evidence that the APC Ban is impeding abortion access in Alaska. While as a general matter “the State is actively engaged in efforts to *expand* access to healthcare for Alaskans in rural communities” where physician networks are limited, Def. Br. at 5 (emphasis added), the one area of care for which the State *restricts* access is abortion care, *see generally* Mot.<sup>11</sup> The effect of the State’s restrictive approach to abortion is evident and undisputed.

Planned Parenthood is currently the only publicly known abortion provider in the state. Pasternack Aff. ¶ 4. Eighty-six percent of Alaska boroughs lack an abortion provider, and 32 percent of women live in those boroughs. *Id.*; *see also Planned Parenthood of the Great Nw. v. State*, No. 3AN-10-12279, 2012 WL 4835506, at § II(e)(1) (Alaska Super. Ct. Oct. 8, 2012) (granting Planned Parenthood broader relief and noting that abortion access in Alaska is “heavily constrained,” and “unavailable in much of rural Alaska”). Because there are only three health centers that provide abortion, patients often must travel long distances for abortion services. Bender Aff. ¶ 25.<sup>12</sup>

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<sup>11</sup> The State suggests that its “help is available” to Alaskans seeking an abortion. Def. Br. at 6. But the only help it offers Alaskans is *court-ordered* Medicaid coverage that it provides under protest. *See Planned Parenthood 2019*, 436 P.3d 984. Were Alaska courts to weaken protection for abortion rights as the State urges, this one form of assistance could well fall by the wayside, a result advocated by the State’s expert witness, Dr. Michael New, with the goal of preventing abortions. Supp. Power Aff. Ex. C (New Dep.) 83:8–87:2.

<sup>12</sup> In an attempt to minimize the impact of the APC Ban, the State mischaracterizes Dr. Pasternack’s testimony on this point as stating 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.” Def. Br. at 4. Dr. Pasternack merely acknowledged that Planned Parenthood currently only dispenses abortion medications in-clinic, Def. Br. Ex. C (Pasternack Dep.) 48:13–19, and in fact explained that “the standard of care across the U.S. for medication abortion is shifting to recognize that medication abortions can be  
(continued . . .)

Not only is abortion available at only three locations, but it is only provided on limited days of the month. Pasternack Aff. ¶¶ 20–22; PI Order at 2. Before this Court issued a preliminary injunction allowing APCs to provide medication abortion, this abortion method generally was only available one or two days per week in Anchorage and weekly elsewhere. Aspiration abortion is still generally available only about once a week in Anchorage, twice monthly in Fairbanks, and monthly in Juneau.<sup>13</sup> Pasternack Aff. ¶¶ 20–22; Power Aff. Ex. D (Pasternack Dep.) 12:19–13:1; Bender Aff. ¶¶ 22, 24. Since the injunction, medication abortion has been available virtually any day a clinic is open. Pasternack Aff. ¶¶ 21–22; Bender Aff. ¶ 11. If the Ban were enjoined in full, Planned Parenthood could continue offering flexible scheduling for medication abortion and, after training APCs in aspiration, could provide aspiration abortion about once a week in Juneau and more often in Anchorage. Pasternack Aff. ¶¶ 22–24; Bender Aff. ¶¶ 20–21.

When appointment availability is limited, patients must either travel farther for care (often from Fairbanks or Juneau to Anchorage) or, if they cannot travel to Anchorage, wait until they find an appointment time in Fairbanks or Juneau that fits their schedule. Bender Aff. ¶ 25; Pasternack Aff. ¶¶ 24, 27, 30. Patients who have already traveled to a health center to receive other care from an APC may need to reschedule an additional appointment at a later day for their abortion. Bender Aff. ¶ 11.

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performed and completed safely in remote locations, when the patient is in a remote location,” *id.* at 46:16–20.

<sup>13</sup> The State supposes, but offers no actual evidence countering Planned Parenthood’s own provider testimony, that appointments may be offered more frequently due to Planned Parenthood’s use of telemedicine.

Patients struggle to access abortion when it is only available far from their home or on limited days for limited hours. *Id.* ¶ 26. Most abortion patients have low incomes, are parents, and/or have inflexible and/or seasonal work schedules. *Id.* ¶ 27; Pasternack Aff. ¶¶ 27–29. Limited access makes it harder for patients to arrange transportation, childcare, and time off from work (often unpaid), all while keeping their decision private. Bender Aff. ¶ 27; Pasternack Aff. ¶ 29. Intimate partner violence is a major problem in Alaska. Seven percent of Alaska women have experienced threats or physical violence from an intimate partner over the past year; still more Alaska women have suffered other kinds of abuse, including reproductive coercion; and these percentages are higher among Alaskans facing unintended pregnancies. Johnson Aff. ¶¶ 20–23; *see also Streur*, 2015 WL 9898581, at \*10 (“Having a child with the abuser tends to tie the mother to her abuser, with potentially fatal results.” (citation omitted)). It can be particularly hard for Alaskans in this situation to arrange a medical appointment, and it is harder when these appointments are as limited as they are in Alaska. Bender Aff. ¶ 26; Johnson Aff. ¶¶ 8, 30–31, 34–35. These barriers are particularly severe for Alaska Native women, who are more likely to live in rural areas and who suffer higher rates of partner coercion and violence. Johnson Aff. ¶ 32. Weather also sometimes interferes with patient travel, staffing, and/or health center operations, a problem compounded when appointment days and rescheduling options are so limited to begin with. Bender Aff. ¶ 28; Pasternack Aff. ¶ 27.

Contrary to the State’s suggestion, Plaintiff has admissible evidence that, as a practical matter, these realities delay burden and delay patients, sometimes for several weeks. Bender Aff. ¶¶ 25–30; Pasternack Aff. ¶¶ 26–31; Ramesh Aff. ¶¶ 65, 69–76, 79–

82; Power Aff. Ex. I (New Dep.) 69:4–9 (defense witness conceding that scheduling conflicts are more likely to occur when appointment days are limited). These delays can make the difference between patients having medication abortion as an option and patients having to undergo a procedure. Bender Aff. ¶ 29; Pasternack Aff. ¶ 26; Ramesh Aff. ¶ 79.<sup>14</sup> The APC Ban also deprives patients of the opportunity to receive care from clinicians with whom they may have an established relationship and feel more comfortable. Bender Aff. ¶ 22; Power Aff. Ex. E (Bender Dep.) 86:16–89:17; Pasternack Aff. ¶ 31.

Moreover, because abortion access is so limited in Alaska, some Alaskans are *unable* to access care and forced to carry to term. Bender Aff. ¶ 30; Ramesh Aff. ¶ 80; Power Aff. Ex. E (Bender Dep.) 92:10–93:13, 111:3–9; Pasternack Aff. ¶ 30. Indeed, the State’s own expert conceded that this is probably occurring. Power Aff. Ex. I (New Dep.) 87:11–88:17, 93:8–94:12 (conceding that, according to studies, restrictions on the provision of abortion prevent some people from accessing abortion); Suppl. Power Aff. Ex. C (New Dep.) 81:15–82:14 (laws that increase the indirect costs of an abortion—such as travel costs, lost wages, and childcare costs—as well as laws that increase travel distance, reduce abortion incidence); *id.* 53:9–13 (economic theory suggests a physician-only law would be particularly likely to prevent some abortions in Alaska, given its rural population and small number of abortion facilities); *id.* 100:9–24 (Alaska’s APC Ban likely

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<sup>14</sup> The State quotes Ms. Bender out of context to suggest that she has only been made aware of this happening rarely. Def. Br. at 15. It omits her clarification that her estimate of “ten times” is an estimate of how many times she can recall directly learning in her clinical work that, because of barriers to care, a patient was prevented from having an abortion *altogether*. Suppl. Power Aff. Ex. A (Bender Dep.) 128:1–21.

prevents some abortions); *cf. Streur*, 2015 WL 9898581, at \*7 (considering the cascading and for some patients prohibitive effects of being delayed past the window for medication abortion).<sup>15</sup>

The fact that the APC Ban delays and prevents patients is borne out by the data since the injunction: despite operational challenges in 2022 posed by the COVID-19 pandemic, far more patients have obtained a medication abortion post-injunction, and more patients have obtained an abortion, period. Pasternack Aff. ¶¶ 21–22; Suppl. Pasternack Aff. ¶¶ 2–3, 7; Bender Aff. ¶ 11; Power Aff. Ex. I (New Dep.) 40:6–41:6 (defense expert conceding post-injunction increase in medication abortions in Alaska); *id.* 118:8–21 (conceding that, even on an overly conservative analysis, he found an over 80 percent likelihood that the injunction was increasing Alaska’s abortion rate); *id.* 90:18–21 (generally, increased access to medication abortion increases abortion access overall); Joyce Aff. ¶¶ 3, 6–9 (finding substantial and statistically meaningful increase in medication abortions post-injunction).

**D. The State Cannot Overcome Plaintiff’s Evidence That the APC Ban Burdens Abortion Access.**

The State fails in its attempt to brush aside Plaintiff’s evidence that the APC Ban burdens abortion access. The State ignores some of Plaintiff’s evidence, improperly dismisses much of it as “impressionistic” and/or hearsay, and attempts to rebut it with unsupported opinions from Dr. New, an avowed anti-abortion activist who has long advocated for limitations on abortion access *as a means of* preventing abortion. *See* Suppl.

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<sup>15</sup> The effects of these obstacles on patients’ health and well-being are set forth at length in Plaintiff’s Motion for Summary Judgment at 10–14.

Power Aff. Ex. C (New Dep.) 80:25–81:8, 110:7–10. These tactics do not alter the plain fact that the APC Ban is a significant barrier to access.

### 1. Plaintiff’s Evidence Is Admissible.

The State claims that “[t]he available quantitative evidence does not establish that the licensed physician requirement has created an access problem.” Def. Br. at 28. As set forth above, Alaska courts reviewing abortion restrictions do not require “quantitative evidence” as to how many patients are harmed in which ways. *See supra* Section II.B. And at any rate, there *is* substantial and admissible quantitative evidence reflecting the APC Ban’s effect here, including: (1) Planned Parenthood data reflecting patients who were past the cut-off for medication and/or aspiration abortion by the time they received care, as well as patients who came to Planned Parenthood seeking an abortion after 11 weeks who ultimately did not receive care in Alaska, *see* Suppl. Power Aff. Ex. H (Plaintiff’s Answer to Interrogatory No. 19); (2) research findings from other states showing that abortion restrictions delay patients, *see* Ramesh Aff. ¶ 75; (3) data quantifying patients who are particularly impacted by limited access, such as those with low incomes, those with parenting responsibilities, and those suffering intimate partner violence, *see* Johnson Aff. ¶¶ 20–21; Ramesh Aff. ¶¶ 72, 78; and (4) Planned Parenthood data showing that medication abortions have increased significantly, and abortions overall have increased, since this Court enjoined the APC Ban as to medication abortion, *see supra* Section II.C.

In addition to this quantitative evidence, Plaintiff has detailed testimony from clinicians describing how they observe the APC Ban affecting patients. Far from being “impressionistic” and “vague,” Def. Br. at 13–16, 27–28, these witnesses testify that they

regularly see patients harmed because they must schedule or reschedule their appointments around limited physician availability rather than receive care from APCs who are there all the time caring for patients, and that these burdens have been greatly reduced since the injunction, Bender Aff. ¶¶ 21–30; Pasternack Aff. ¶¶ 17, 29–31; Suppl. Power Aff. Ex. B (Pasternack Dep.) 34:9–19, 78:3–80:2, 82:9–19, 83:6–18, 84:8–15; *id.* Ex. A (Bender Dep.) 81:23–82:24, 89:19–93:13, 96:10–24, 97:10–19, 102:7–25, 108:5–109:3. Even though not all patients volunteer this information, both Dr. Pasternack and Ms. Bender were able to recall instances when, prior to the injunction, patients seeking a medication abortion could not do so because they were beyond the gestational age limit, when patients could not obtain an abortion at all because they were beyond the gestational age limit, and when patients expressed frustration over not being able to obtain their abortion sooner because of physician schedules. Bender Aff. ¶ 30; Pasternack Aff. ¶¶ 17, 29–31; Suppl. Power Dep. Ex. B (Pasternack Dep.) 110:2–13, 116:22–117:12, 117:16–118:24, 119:23–120:13, 128:15–129:5; *id.* Ex. A (Bender Dep.) 68:7–69:22, 71:4–20, 72:15–73:10, 110:25–111:9, 128:4–21.<sup>16</sup>

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<sup>16</sup> The State mischaracterizes Dr. Pasternack’s and Ms. Bender’s deposition testimony as vague. Def. Br. at 14, 15, 27. Read in context, it is clear that both witnesses were looking back over years of practice and estimating the frequency with which they see various types of patients, and patient burdens, because Planned Parenthood does not track this information in any aggregable form. *See, e.g.*, Suppl. Power Aff. Ex. B (Pasternack Dep.) 116:22–118:24 (explaining that while not all patients report their circumstances to her, she estimates that between 10 and 25 percent of her patients travel from Alaska Native areas remote from the clinic; that patients “frequently” travel to Anchorage from other areas, including Juneau and Fairbanks; and that on most days when she provides care, a patient presents who cannot be treated because they are past the gestational cut-off).

The State is wrong to contend that this testimony is inadmissible hearsay. Provider testimony falls under several hearsay exceptions where, as here, the providers are both medical providers as well as experts. *See* Alaska R. Evid. 803(1)–(4) (listing exceptions for statements with indicia of reliability, such as those describing a contemporaneous or recent “event or condition,” those made under stress, those describing state of mind, and statements that are pertinent to “medical diagnosis or treatment”); Alaska R. Evid. 803(23) (residual exception); Alaska R. Evid. 703 (allowing experts to rely on hearsay in forming their opinion).

The statements made to providers by patients about the circumstances of their lives have circumstantial guarantees of trustworthiness under Alaska Rule of Evidence 803(23) because they were made in an effort to secure medical treatment—an abortion—a context in which declarants are motivated to provide accurate information. Indeed, Alaska Rule of Evidence 803(4) recognizes statements about medical history or past or present symptoms as trustworthy *per se* when made for purposes of medical treatment. Courts view such statements as generally trustworthy because the declarant must convey accurate information to obtain appropriate treatment. *See Sluka v. State*, 717 P.2d 394, 399 (Alaska Ct. App. 1986) (“[A] fact reliable enough to serve as a basis for diagnosis and treatment is also reliable enough to escape hearsay proscription.”). Under the logic of Alaska Rule of Evidence 803(4), as well as that of the more general residual hearsay exception set forth in Rule 803(23), Dr. Pasternack’s and Ms. Bender’s testimonies are proper. *See United States v. Sanchez-Lima*, 161 F.3d 545, 547 (9th Cir. 1998) (“Hearsay evidence sought to be

admitted under [the federal hearsay exception] must have circumstantial guarantees of trustworthiness equivalent to the listed exceptions to the hearsay rule.”).

Indeed, this is precisely the type of testimony that the Alaska courts have routinely relied on in striking abortion restrictions. *See, e.g., Streur*, 2015 WL 9898581, at \*7, \*9–12 (relying on testimony of Planned Parenthood’s executive director and physicians); *Planned Parenthood of Alaska*, 2003 WL 25446126, at § III (noting great weight placed on “testimony of . . . qualified experts who by training and experience have formed opinions based on personal knowledge,” including abortion provider physicians).

As one court observed in evaluating a challenge to a parental consent law: “It is not required that young women themselves attest to the difficulty they face in complying with the Act’s provisions; abortion providers are the most expert among us as to how laws affecting patients’ access will function in practice.” *Memphis Planned Parenthood, Inc. v. Sundquist*, 2 F. Supp. 2d 997, 1008 (M.D. Tenn. 1997), *rev’d*, 175 F.3d 456 (6th Cir. 1999); *see also Planned Parenthood Ass’n of Atlanta Area, Inc. v. Harris*, 670 F. Supp. 971, 977–78 (N.D. Ga. 1987) (non-physician clinic director permitted to make generalizations on the basis of her experience regarding needs, behaviors, and experiences of minors seeking abortions and to predict consequences of legislation imposing restrictions); *Hodgson v. Minnesota*, 648 F. Supp. 756, 766–67 (D. Minn. 1986) (relying on testimony of clinic counselor regarding her conversation with minors in support of her conclusion that forced parental notification does not promote family integrity or communication), *rev’d*, 853 F.2d 1452 (8th Cir. 1988). In these cases, individuals with extensive experience serving women and minors in need of abortion services were permitted to describe the circumstances faced

by their patients as well as their motivations and behaviors; to set forth the concerns that informed their patients' decisions; and to predict how they would respond to or be burdened by legislation having an impact on those concerns. The same analysis applies here to find provider testimony admissible.

Planned Parenthood's provider testimony is bolstered by uncontroverted expert testimony, citing high quality research, that "when qualified providers are prevented from seeing patients, appointment availability is reduced, creating bottlenecks and delaying patient access to care." Ramesh Aff. ¶ 68; *see also id.* ¶ 71 ("When appointment availability is limited, people must either travel farther for care (if they can travel and can find a clinic where they can be seen sooner) or, if they live near a clinic with limited capacity and cannot travel, wait until they find an appointment time that fits their schedule. Both alternatives entail delay and other burdens, and both may be inaccessible for some patients.").

In addition to trivializing Plaintiff's evidence, the State plays "no true Scotsman," presenting a "moving target" of evidence they claim (without any legal support) that Plaintiff should have adduced but did not. *Merriman v. Berryhill*, No. 16-CV-50073, 2017 WL 2345551, at \*8 & n.10 (N.D. Ill. May 30, 2017); *see* Def. Br. at 12. The State faults Plaintiff for not producing certain data, such as how many patients unsuccessfully seek a medication abortion, but these exact data do not in fact exist within Plaintiff's records. *See* Def. Br. at 12, 14–15, 27, 29; Suppl. Power Aff. Ex. G (Marshall Dep.) 44:25-45:8 (Planned Parenthood does not track patients who would prefer medication abortion but are beyond the gestational age cut-off); 80:4–22 (Planned Parenthood is "not able to collect data around scheduling difficulties"); 53:22–54:2 (no way for Planned Parenthood wait

time data to account for rescheduled or canceled appointments); 62:10–15 (Planned Parenthood does not collect data about why patients choose particular appointment dates); 48:19–49:19, 64:6–11 (not possible to collect data showing the number of patients who were prevented from getting an abortion because a provider was not available, because cannot track something that does not occur).<sup>17</sup>

The State also complains that Plaintiff has ceased producing monthly abortion data, and claims this is “doubtless because Planned Parenthood recognizes that this data is unlikely to support its claim that the law caused an access problem.” Def. Br. at 30. That is not so. The data continue to support Planned Parenthood’s claims. *See* Suppl. Pasternack Aff. ¶ 7. Plaintiff did not “withhold” these data. Rather, there is no basis for ongoing productions where discovery is closed and cross-motions for summary judgment are pending. Should the case not be resolved on summary judgment, Planned Parenthood will of course consider whether supplemental evidence would assist the Court at trial and will revisit supplementation at that time.

Finally, the State argues that although it did not seek such information in discovery, it was incumbent upon Plaintiff to calculate the distance Alaska patients travel to access abortion services and the percentage of abortions covered by Medicaid. This is perplexing, as the *State* itself requires providers to report to it detailed information for each abortion, including where the patient resides and whether they are insured through Medicaid. AS

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<sup>17</sup> With no consideration of the feasibility, time, or extensive cost that would be involved in doing so, the State also suggests that Plaintiff could have conducted “a data-intensive study . . . to evaluate whether the licensing requirement presents an access problem.” Def. Br. at 12 n.44; *id.* at 14.

18.50.245; Alaska Dep't of Health, Report of Induced Termination of Pregnancy (July 2022), [https://health.alaska.gov/dph/Vitalstats/Documents/PDFs/itop/ITOP\\_form.pdf](https://health.alaska.gov/dph/Vitalstats/Documents/PDFs/itop/ITOP_form.pdf).

More broadly, notwithstanding the State's laundry list of evidence it believes Plaintiff should have produced, Plaintiff has shown that the APC Ban burdens abortion access, and summary judgment for the State is inappropriate.

## 2. The State's Attempt to Rebut Plaintiff's Evidence Fails.

The State also tries to rebut Plaintiff's evidence with patently biased and noncommittal opinion testimony from Dr. New, an avowed anti-abortion activist who described his assertions not as expert opinion but as "my argument," Suppl. Power Aff. Ex. C (New Dep.) 47:19, 48:10, 54:13, and who elsewhere advocates for restrictions on access as a *means* of forcing women to carry to term, *id.* 80:25–81:8, 110:7–10. Dr. New appears only to opine that the data do not establish that the APC Ban *is*, as he puts it, "significantly" impeding access, not that the data establish the *contrary*. *See* New Aff. at 22; Suppl. Power Aff. Ex. C (New Dep.) 28:13–30:7. Indeed, Dr. New concedes that the Ban is likely preventing some Alaskans from accessing abortion care altogether. Suppl. Power Aff. Ex. C (New Dep.) 100:5–24.

Even assuming for the sake of summary judgment only that Dr. New's testimony is admissible, Dr. New fails to effectively rebut Plaintiff's evidence that the APC Ban is impeding access. The State points to Dr. New's assertion that the increase in abortion totals post-injunction is not "statistically significant" (defined by Dr. New as less than 10 percent likely to be due to chance). This observation is both inaccurate and meaningless, by his own admission. It is inaccurate because Dr. New failed to use the most appropriate test for

significance: a one-tailed test. *Id.* 75:12–15 (conceding that a one-tailed test was better in this situation). Dr. New admitted that under a one-tailed test, which he conceded is better, there *is* a statistically significant increase in the number of abortions post-injunction. *Id.* 75:20–24 (under one-tailed test, the data he analyzed did show a statistically significant increase).

Dr. New’s observation is also meaningless for three reasons. *First*, as Dr. New concedes, even on a test that is more conservative than necessary, it is over 80 percent likely that abortion rates increased as a result of the injunction. *Id.* 118:8–21. (Indeed, on the more appropriate test, that likelihood would be over 90 percent. *Id.* 75:16–23; *see also* Joyce Aff. ¶ 4).<sup>18</sup> *Second*, as Dr. New concedes, even with an impactful legal change, statistical significance is hard to find on a limited data set such as this with less than a year of post-injunction data. Suppl. Power Aff. Ex. C (New Dep.) 34:19–35:10 (admitting that, even on his overly conservative test for significance, the observed increase in abortion numbers may reach statistical significance if it continues over time). And *third*, given that the injunction expanded access for *medication* abortion only, the more relevant evidentiary question is whether *medication* abortion rates increased. They did, significantly, even after controlling for other trends. Joyce Aff. ¶¶ 3–5; *cf.* Suppl. Power Aff. Ex. C (New Dep.)

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<sup>18</sup> Of course, the civil standard of proof is neither 90 percent nor 80 percent likelihood. *See Buntin v. Schlumberger Tech. Corp.*, 487 P.3d 595, 605 (Alaska 2021) (“Absent a statutorily specified higher burden or particularly important individual interests at stake, it is well established that the standard of proof in civil cases is a preponderance of the evidence.”).

40:6–11, 43:6–11 (conceding that medication abortion rates increased, and that he did not bother to try to control for trends to assess the significance of that increase).<sup>19</sup>

The State’s attempt to use Dr. New to draw conclusions about patient “wait times” is similarly flawed. The State argues that because wait times (for all abortions, not just medication abortions) have not measurably decreased since the injunction, the APC Ban cannot be deemed the cause of delay in patients accessing care. Def. Br. at 11–13. This argument, however, ignores known limitations of the data on which Dr. New relies. The data are incomplete because they do not include various forms of delay that arise when scheduling options are limited: *e.g.*, delay while patients work out their schedule and other logistics, such as transportation, in order to find an appointment that works; delays from rescheduling appointments; or delays that make it impossible for patients to receive an abortion with Planned Parenthood. Suppl. Power Aff. Ex. G (Marshall Dep.) 18:10–17, 20:24–21:9; Joyce Aff ¶¶ 10–12.<sup>20</sup> Moreover, while Dr. New compares annual data prior

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<sup>19</sup> The State relies on Dr. Ramesh’s testimony that the organization she provides for, Virginia League for Planned Parenthood (“VLPP”), has not seen a marked increase in abortion numbers since that state permitted it to integrate APRNs in 2021. Def. Br. at 30. Notwithstanding the fact that this testimony is from outside the state, the State fails to note key context that Dr. Ramesh provided: first, VLPP, as a primarily-urban provider with a high-volume patient population, employs full-time physicians; and second, the pandemic has caused substantial staffing shortages and service interruptions that have affected abortion access since 2020, at the same time APRNs were beginning to provide abortion care at VLPP. *See* Suppl. Power Aff. Ex. E (Ramesh Dep.) 65:9–66:7.

<sup>20</sup> At his deposition, Dr. New revealed that he did not understand precisely what these data measured, and conceded that he had unresolved questions about the data and that he had not been made aware of Plaintiff’s evidence of major gaps in how these data reflect delay. Suppl. Power Aff. Ex. C (New Dep.) 45:13–49:22. He also appeared to think, incorrectly, that the data measured back to the time the patient first contacted the clinic, rather than the time they made an appointment. *Id.* 43:13–19.

to 2022 with monthly data post-injunction, the pattern of rescheduling by both patients and staff may vary from month to month because of weather, illness, or other events that may be more prevalent at different times of the year. Joyce Aff. ¶ 11. Additionally, these wait times are averages for all abortion methods, so they would not reflect whether the injunction reduced delays for medication abortion patients specifically.<sup>21</sup> *Id.*

**E. It Is Legally Immaterial Whether There Are Other Obstacles, Alongside the APC Ban, to the Provision and Obtainment of Abortion Care.**

In addition to questioning whether Alaskans really face meaningful obstacles in accessing abortion care, the State minimizes the role the APC Ban plays in this problem by stressing that health care is challenging in Alaska generally, and by asserting that Planned Parenthood could itself improve access by hiring more per diem physicians or full-time physician staff. These arguments misunderstand both the legal standard and the facts.

The test, in Alaska and elsewhere, for whether a challenged abortion restriction infringes on privacy rights is not whether it is the *sole* obstacle to people obtaining care. Courts have long recognized myriad social obstacles to abortion access: *e.g.*, patients’ financial constraints and challenging life circumstances (such as lack of childcare, paid time off, reliable transportation, and support from partners or family), *Streur*, 2015 WL 9898581, at \*7 (considering the effect of Medicaid funding restriction on “poor women”);

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<sup>21</sup> The State notes as factual background, Def. Br. at 11–12, but does not appear to rely in its argument section on Dr. New’s entirely irrelevant opinion that Alaska is not an “outlier” because its abortion rates are not markedly lower than those of other states. In making this assertion, the State fails to note that Alaska’s rates *are* lower than virtually all the states that allow APCs to provide abortion care. *Compare* New Aff. ¶ 11 (comparing Alaska’s abortion rate with that of other states), *with* Ramesh Aff. ¶ 56 (listing states that allow APCs to provide abortion care).

*id.* at \*17 (“To an impoverished woman without recourse to an abortion, the crisis may be extreme. Indigent women often face a panoply of stressors, including large families, homelessness, addiction, their own adolescent immaturity, and domestic violence.”); and the stigmatization and professional constraints that limit the network of local professionals willing and able to provide this care, *Planned Parenthood of the Great Nw.*, 2012 WL 4835506 (considering the stigma and coercion that limits provider network). As Planned Parenthood has shown, Alaska patients face all of these obstacles, compounded by the difficulties of what the State’s own witness calls “the tyranny of distance” that constrains many rural patients’ access to care. Suppl. Power Aff. Ex. F (Crum Dep.) 105:17–18.

Rather, the test is whether a challenged restriction burdens access in the “real [ ] world” in which providers and patients live. *State, Dep’t of Health & Soc. Servs.*, 28 P.3d at 910. The APC Ban has this effect; one proof of that is how effective the PI Order has been. It is undisputed that medication abortions can now be offered on all service days, as opposed to (pre-injunction) once or twice a week and at a physician’s discretion. Bender Aff. ¶ 11; Pasternack Aff. ¶ 22. It is undisputed that Planned Parenthood has been able to provide abortion care for more patients, and more patients have been able to access medication abortion. Similarly, the evidence is unrebutted that, if legally permitted to do so, APCs could offer aspiration services more frequently and reliably. Bender Aff. ¶ 20; Pasternack Aff. ¶¶ 30–31. This alone is sufficient to show that the APC Ban burdens access and compounds other barriers to care.

The State’s claim that Planned Parenthood could increase its physician staffing and offer abortion services more regularly is irrelevant. As the Seventh Circuit has explained

in rejecting a state’s argument that Planned Parenthood could have mitigated the burdens of the statute by making different business decisions:

[I]t [is not] appropriate for an opposing party or a court to dictate the best use of resources for a business, provided its choices are within the range of reasonableness—but particularly in the case of a non-profit agency with limited funding seeking to provide the most efficient health care services to a mostly poor population.

*Planned Parenthood of Ind. & Ky., Inc. v. Comm’r of Ind. State Dep’t of Health*, 896 F.3d 809, 823 (7th Cir. 2018), *vacated and remanded on other grounds sub nom. Box v. Planned Parenthood of Ind. & Ky., Inc.*, 141 S. Ct. 184 (2020); *see also Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 916 (9th Cir. 2014) (considering testimony that, because the challenged restriction would reduce patient volume, plaintiffs “may have to close” their Flagstaff clinic if it takes effect, along with evidence of predicted effects of such a closure). In other words, “[c]ourts must consider the impact of the . . . law based on the reality of the abortion provider and its patients, not as it could if providers and patients had unlimited resources.” *Planned Parenthood of Ind. & Ky.*, 896 F.3d at 824.

The Seventh Circuit’s approach is consistent with the approach taken by Alaska courts. For example, the court in *Planned Parenthood 2019* did not ask whether Planned Parenthood could simply provide free or lower-cost services to replace the Medicaid funding at issue in that case. 436 P.3d 984. Similarly, the court in *Valley Hospital Ass’n* did not ask whether patients could just go to a hospital outside of Mat-Su. 948 P.2d 963. And this Court in *Planned Parenthood of the Great Northwest v. State* considered the effects of the parental notice law in the context of the limited days on which Planned Parenthood offers abortion, without asking whether Planned Parenthood could mitigate

those effects by hiring more physicians and offering abortion care on more days. 2012 WL 4835506, at § IV(e)(3) (granting Planned Parenthood more fulsome relief); *id.* at § IV(e)(6) (striking down requirement that physicians personally notify patients’ parents, as “cumbersome and irrational” given Planned Parenthood’s “independent contractor structure” of physician staffing).

In any event, the State puts forward no evidence to rebut Planned Parenthood’s testimony that it cannot sustainably increase its physician staffing. Pasternack Aff. ¶¶ 20-21; Suppl. Pasternack Aff. ¶¶ 4-5. Hiring full-time physicians is financially unsustainable for Planned Parenthood. Pasternack Aff. ¶ 20; Suppl. Pasternack Aff. ¶ 5. This is uncontroverted.<sup>22</sup> Moreover, the services Planned Parenthood offers are relatively low-risk and not suitable to most physicians’ practices, and it can be difficult to recruit full-time physicians due to fear of ostracism or harassment, especially outside of Anchorage and Juneau. Pasternack Aff. ¶ 20. To cope with this problem and continue offering services in Alaska, Planned Parenthood hires per diem physicians. *Id.* ¶ 21. Hiring per diems requires both financial resources and the administrative resources to train, onboard, integrate, and oversee additional staff. *Id.*; *see also* Suppl. Pasternack Aff. ¶ 4. And on days when Planned Parenthood staffs a clinic with a per diem physician, it must concentrate

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<sup>22</sup> The State points out that another Planned Parenthood affiliate based in Virginia employs full-time physicians. As that affiliate’s medical director explained, it can only do so because it has urban health centers that provide a high volume of *second-trimester* abortion and other complex care, and it sees roughly five times as many abortion patients per year as Plaintiff does. Suppl. Power Aff. Ex. E (Ramesh Dep.) 64:25-65:15.

procedures on that day to ensure a full schedule. Suppl. Power Aff. Ex. B (Pasternack Dep.) 163:5–23.

The State makes much of a handful of emails from Planned Parenthood’s Medical Director stating that it was “fully staffed” with physicians, but her emails were not about whether Planned Parenthood was able to fully meet patient needs; they reflected nothing more than that, at the time of the emails, Planned Parenthood had as many per diem arrangements as it could sustain in terms of training and onboarding, oversight, scheduling, arranging and paying for travel, and payment. *Id.* 144:7–16, 195:24–196:13. Even staffed at this level, Planned Parenthood has in the past been unable to find a local Fairbanks provider, and has had to fly per diems there from Anchorage once a month. *Id.* 154:24–156:14.

Importantly, contrary to the State’s suggestion, Planned Parenthood is by no means unique in relying on APCs as lead clinicians. Suppl. Power Aff. Ex. D (Spetz Dep.) 75:5–8 (“[I]n rural communities in Alaska, there are many clinics where the only clinician on site is an advanced practice clinician.”); Spetz Aff. ¶ 50 (federally-qualified health centers, which serve low-income populations, employ more APCs than physicians); *id.* ¶ 67 (“PAs are more likely than physicians to provide care in rural areas and to low-income and underserved populations.”); *id.* ¶ 92 (there are more than three times as many APCs practicing in rural Alaska as there are physicians); *cf.* Def. Br. at 5 (“[S]ome communities simply are not large enough to support a full-time provider.”). The State clearly recognizes this reality in the broad scope of practice it generally affords APCs and even occupationally-trained community health aides, and in the fact that it does not require

APCs to practice alongside physicians. *See* Power Aff. Ex. C (Crum Dep.) 71:8–16. What is unique is the State’s restriction of abortion care and not other comparably low-risk care.

Because some of Planned Parenthood’s clinics have a lower volume of abortion patients, the State also speculates that perhaps in Alaska the abortion “supply” exceeds “demand,” and suggests that if the “demand” for abortion were higher, Planned Parenthood could sustain a higher level of staff. Def. Br. at 26. This unfounded speculation misapplies the concepts of supply and demand and conflates “demand” with need. Joyce Aff. ¶¶ 14–16. In rural areas, the patient volume or “demand” is necessarily low, but those patients still need timely care; that is a key challenge for rural providers. Suppl. Pasternack Aff. ¶ 6. And a person may need care, but be unable to access it, for example, because the barriers are too high. *Id.* Finally, the State’s speculation is contrary to the evidence; that abortion numbers have increased overall, and dramatically for medication abortion, shows that the APC Ban was preventing Planned Parenthood from meeting Alaskans’ need for care.

The State’s theories about what Planned Parenthood could do differently aside, what is beyond dispute is that since the injunction, Planned Parenthood has been able to integrate medication abortion into the care its APCs provide all-day, most days the clinic is open. The benefits for patients have been evident. Not only has Planned Parenthood been able to offer far more flexible scheduling and provide care for more patients, but patients have expressed greater satisfaction in their care, and care has been more continuous because patients can now receive treatment from the same professionals with whom they have already shared intimate details of their lives. Bender Aff. ¶¶ 22–23. Moreover, since the injunction, physicians have been more available to perform more complex procedures,

benefiting patients overall. Suppl. Power Aff. Ex. B (Pasternack Dep.) 192:2–25; *cf.* Spetz Aff. ¶ 51 (quoting Institute of Medicine report’s finding that expanded APC provision “free[s] physicians to handle more complex cases”).<sup>23</sup>

The State seeks to deny Alaskans these benefits, and the further benefits of integrating APCs into aspiration care, simply because the State does not think the abortion access problems in Alaska are dire enough to merit court intervention. As discussed above and in Planned Parenthood’s Motion for Summary Judgment, decades of Alaska precedent hold otherwise.

#### IV. CONCLUSION

For the reasons stated above, the State’s Motion for Summary Judgment should be denied.

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<sup>23</sup> Beyond evidence specific to its own clinics, Plaintiff has also produced evidence that APCs are more likely than physicians to practice in rural areas and that, where states have lifted unnecessary regulations on APCs, that has made APCs more inclined to practice there, further increasing the supply of providers and improving health outcomes. Suppl. Power Aff. Ex. D (Spetz Dep.) 25:22–31:13; Ramesh Aff. ¶¶ 46, 67. Based on these general facts, lifting the APC Ban could well expand access to abortion and other care in rural areas outside Planned Parenthood’s clinics, though this fact is not necessary to Plaintiff’s claim.

Dated this 29th day of August, 2022.

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**CERTIFICATE OF SERVICE**

This certifies that on August 29, 2022, a copy of the foregoing was served via email on:

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