

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

**PLAINTIFF'S PROPOSED FINDINGS OF FACT
AND CONCLUSIONS OF LAW**

INTRODUCTION

Due to its vast geography, low population volume, and shortage of physicians, the State of Alaska relies heavily on advanced practice clinicians (“APCs”) for the delivery of health care services and encourages them to practice at the top of their license. In Alaska, APCs can prescribe medication, perform biopsies, provide vasectomies, treat miscarriage, and deliver babies. Indeed, there is only one type of health care that APCs are prohibited by law from providing: abortion, *see* AS 18.16.010(a)(1) (the “APC Ban”). The result of the APC Ban—which does nothing to further health and safety—is to limit the pool of providers who are qualified, able, and willing to provide this care, which, in turn, burdens patients and restricts access to abortion by reducing appointment availability and flexibility. This compounds other burdens that Alaskans already face in

accessing health care, including access to transportation, the challenges of severe weather, inflexible job schedules, and caregiving responsibilities; compromises patient privacy and autonomy; and delays or even prevents care.

Alaska’s privacy clause protects a patient’s fundamental right and ability to choose an abortion, patient autonomy, and private medical decisionmaking—all of which have been compromised by the APC Ban. The equal protection clause protects against discrimination, including when a fundamental right is at issue. Under both, strict scrutiny applies. The State has questioned whether the burdens Alaskans face in accessing abortion are caused by the APC Ban and, even if they are, whether they are sufficiently substantial to trigger strict scrutiny. But the APC Ban need not be the only impediment to accessing abortion in Alaska to be unconstitutional, and neither Alaska’s privacy nor its equal protection guarantee require the onerous threshold showing the State suggests. At any rate, the burdens imposed by the APC Ban, including the myriad devastating effects of continuing an unwanted pregnancy for longer than necessary, are more than sufficient to clear whatever showing is required. The State has offered *no* justification for the APC Ban and concedes there is no medical reason APCs cannot safely provide this care. The APC Ban therefore cannot survive any level of review, much less the strict scrutiny review which applies here, and must be permanently enjoined.

Accordingly, Plaintiff Planned Parenthood Great Northwest, Hawai’i, Alaska, Indiana, Kentucky (“Planned Parenthood”), by and through its undersigned counsel, respectfully submits the following proposed findings of fact and conclusions of law:

FINDINGS OF FACT

I. Factual and Procedural Background

1. AS 18.16.010(a)(1) provides that “[a]n abortion may not be performed in” Alaska unless it “is performed by a physician licensed by the State Medical Board.” The penalty for violating the APC Ban is a fine of up to \$1,000, or up to five years’ imprisonment, as well as other civil penalties. AS 18.16.010(c), (e).

2. APCs include two groups—advanced practice registered nurses (“APRNs”) and physician assistants (“PAs”). APRNs include certified nurse midwives (“CNMs”) and nurse practitioners (“NPs”). [Tr. 180:25–182:2 (Spetz)]. In Alaska, APRNs and PAs are regulated by the Alaska State Board of Nursing (the “Board of Nursing”) and the Alaska State Medical Board (the “Medical Board”), respectively. [Tr. 195:25–197:9 (Spetz)].

3. Planned Parenthood is a not-for-profit corporation and the only publicly-identified abortion provider in Alaska. [Tr. 41:9–11, 413:4–9 (Pasternack)]. It operates three health centers in the state, in Fairbanks, Anchorage, and Juneau. [Tr. 41:1–5 (Pasternack)]. Planned Parenthood provides a broad range of reproductive and sexual health services including, but not limited to, well person examinations, birth control, testing and treatment for sexually transmitted infections, miscarriage care, cancer screening, gender-affirming care, pregnancy testing, and abortion. [Tr. 34:23–35:3 (Pasternack); 477:21–478:6 (Bender)]. APCs provide most of Planned Parenthood’s services. [Tr. 477:21–479:8 (Bender)]. Planned Parenthood employs CNMs and NPs. [Tr.

48:15–21 (Pasternack)]. It also hires PAs on a per diem basis and would consider employing PAs for open APC staff positions in the future. [Tr. 48:15–49:2 (Pasternack)].

4. Planned Parenthood provides medication abortion at all of its health centers through 11 weeks of pregnancy. [Tr. 43:15–17 (Pasternack)]. It provides aspiration abortion, a type of procedural abortion, at its Fairbanks and Juneau health centers through 13 weeks, 6 days of pregnancy, and aspiration and other procedural abortions through 17 weeks, 6 days at its Anchorage health center. [Tr. 45:19–46:1 (Pasternack)]. Because of the APC Ban, Planned Parenthood has had to rely on per diem physicians to provide abortions, even though providing abortion is otherwise within APCs’ scope of practice, resulting in limited abortion availability. *Infra* ¶¶ 40, 47, 60–62, 64–65.

5. In December 2019, Planned Parenthood brought suit to enjoin AS 18.16.010(a)(1) as applied to APCs, arguing that, because it restricts the full range of qualified abortion providers and thereby reduces abortion availability, the APC Ban violates patients’ fundamental right to privacy, including the fundamental right to abortion, as guaranteed by article I, section 22 of the Alaska Constitution; patients’ fundamental right to liberty as guaranteed by article I, section 1 of the Alaska Constitution; and patients’ and APCs’ right to equal protection, as guaranteed by article I, section 1 of the Alaska Constitution. *See generally* Compl. Planned Parenthood sued the State of Alaska, pursuant to AS 44.80.010, as well as the individual members of the Medical Board and the Board of Nursing in their official capacities (collectively, the “State”). *See* AS 08.64.010; AS 08.64.105, 08.64.326, 18.16.010; 08.68.270, 08.68.275.

6. Planned Parenthood requested a limited preliminary injunction in June 2021, seeking to allow APCs to provide medication abortion. *See generally* Mem. of Law in Supp. of Pl.’s Mot. for Prelim. Inj. (June 21, 2021). On November 2, 2021, the court granted Planned Parenthood’s motion and issued a preliminary injunction (the “Injunction”), allowing APCs to provide medication abortion pending the court’s final judgment.

7. On May 23, 2023, the court denied the parties’ cross motions for summary judgment finding that there were issues of fact as to whether the APC Ban sufficiently burdened patients’ rights so as to trigger strict scrutiny review. *See generally* Order on Cross Mots. for Summ. J. (May 23, 2023) (“SJ Order”).

8. The parties conducted a trial before the court from November 13 to 17, 2023. At trial, Planned Parenthood presented live testimony from five witnesses, including:

9. **Tanya Pasternack, M.D.**, the Alaska Medical Director for Planned Parenthood and a board-certified obstetrician-gynecologist. [Tr. 33:5–14, 34:17–19 (Pasternack)]. Dr. Pasternack began working as a per diem physician at Planned Parenthood in 2013 and became the Alaska Medical Director in 2016. [Tr. 33:15–18, 35:14–16 (Pasternack)]. As the Alaska Medical Director, Dr. Pasternack ensures that Planned Parenthood physicians and APCs provide high quality medical care, supervises procedural abortion staffing, recruits and onboards new physicians, and serves as a consultant for physicians and APCs when they have questions about complex care. [Tr. 35:17–36:20 (Pasternack)]. Dr. Pasternack oversees new physicians providing procedural abortion and trains APCs on advanced gynecological skills. [Tr. 37:1-4, 430:18–24

(Pasternack)]. She supervises the Lead Clinician for the Alaska health centers, who is an APC. [Tr. 345:2–6 (Bender)]. She also treats patients, including by providing abortions. [Tr. 34:14–17 (Pasternack)]. In addition to her position with Planned Parenthood, Dr. Pasternack works as an OB/GYN in private practice and provides hospital-based care through that role. [Tr. 33:5–9; 42:6–16 (Pasternack)]. Dr. Pasternack is an expert in the norms and standards for providing gynecological services, including abortion; the practice of training medical staff, including non-physicians; and APCs’ scope of practice, as well as their competency providing reproductive health care in Alaska. [Tr. 38:1–17 (Pasternack)].

10. **Amy Bender, MSN, ARNP, FNP-BC**, the former Lead Clinician in Alaska for Planned Parenthood who continues to see Alaska Planned Parenthood patients, including medication abortion patients, as a telehealth per diem provider. [Tr. 342:23–25, 345:20–346:4, 342:17–343:7, 347:11–16 (Bender)]. In addition to her telehealth duties with Planned Parenthood, Ms. Bender currently works as a nurse practitioner in Albany, New York. [Tr. 342:17–343:7 (Bender)]. She is licensed in Alaska as a trained and board-certified family nurse practitioner. [Tr. 340:22–341:18 (Bender)]. She has extensive training in sexual and reproductive health, which encompasses all aspects of caring for pregnant patients, including providing abortion. [Tr. 341:22–342:16 (Bender)]. As Lead Clinician, Ms. Bender supervised Planned Parenthood’s team of APCs, all of whom specialized in women’s or family health, including reproductive health care like abortion. [Tr. 343:9–344:4 (Bender)]. She also provided direct clinical care to patients, including preventative care, family planning counseling and services, cancer screening

and diagnosis, miscarriage management, and abortion services, including medication abortion after the Injunction. [Tr. 344:5–345:1, 346:5–347:20, 348:9–349:14 (Bender)]. Ms. Bender is an expert in the provision of reproductive health care in Alaska. [Tr. 350:11–19 (Bender)].

11. **Shanthi Ramesh, M.D.**, an expert in the norms and standards for providing gynecological services, including abortion and miscarriage management, and the practice capabilities of medical staff, including non-physicians. [Tr. 244:9–22 (Ramesh)]. She is a physician who is board certified in obstetrics and gynecology and in complex family planning. [Tr. 242:1–3 (Ramesh)]. Dr. Ramesh has been the Chief Medical Officer at Virginia League for Planned Parenthood since 2017. [Tr. 238:15–20 (Ramesh)].

12. **Joanne Spetz, Ph.D.**, an expert in the advanced practice nursing workforce, the nature of APC scope of practice regulations in Alaska and other states, and how APC scope of practice regulations affect quality of care, cost of care, and access to care for patients. [Tr. 176:16–177:12 (Spetz)]. She is a professor at the University of California San Francisco and the director of its Institute for Health Policy Studies. [Tr. 174:13–19 (Spetz)]. She studies labor markets (including the labor market involving nurses in particular) and has published extensively on the nursing workforce and health care delivery, including on APCs. [Tr. 174:5–175:7 (Spetz)].

13. **Ingrid Johnson, Ph.D.**, an expert in intimate partner violence and rural-urban dynamics in Alaska, including the unique risks and barriers women experiencing intimate partner violence face. [Tr. 576:7–577:2 (Johnson)]. She is an associate professor at the University of Alaska Anchorage’s Justice Center, where she teaches classes,

including on victimization and rural justice. [Tr. 565:18–566:16 (Johnson)]. Dr. Johnson also serves as the principal investigator for the Alaska Sexual Assault Kit Initiative research project and the Alaska Victimization Survey. [Tr. 572:14-17, 574:9–12 (Johnson)].

14. Ms. Bender and Drs. Pasternack, Ramesh, and Johnson are credible witnesses. Each was qualified as an expert in her field. *Supra* ¶¶ 9–13. Additionally, Dr. Pasternack and Ms. Bender are both experienced women’s health practitioners, including at Planned Parenthood’s Alaska clinics. As such, they are familiar with Planned Parenthood’s patient population and the barriers they face in accessing abortion.

15. The State did not put on an affirmative case or present any witnesses or evidence at trial.

II. Abortion Is an Essential Component of Basic Health Care.

A. Abortion Generally

16. Approximately one in four women in the United States will have an abortion by the time she is 45. [Tr. 293:25–294:2 (Ramesh)]. People seek abortions for a variety of medical, familial, economic, and personal reasons. For example, many are already parents and decide they cannot have another child. Some are in relationships where they experience intimate partner violence and want to escape their abusive partners. Others want to continue their education. Some patients have abortions to preserve their life or health. Others have become pregnant as a result of rape or incest and do not want to continue their pregnancies. [Tr. 293:9–24 (Ramesh)].

17. Throughout the country, most abortions occur during the first trimester of pregnancy. [Tr. 261:10–14 (Ramesh)]. Approximately 90 percent of abortions in the United States occur during the first 13 weeks of pregnancy, and in Alaska, 89 percent are performed during the first 12 weeks. [Tr. 261:17–18 (Ramesh)].

18. There are two primary methods of abortion: medication abortion and procedural abortion. [Tr. 251:8-15 (Ramesh)]. In the first 11 weeks of pregnancy patients have a choice between medication abortion and aspiration, which is a form of procedural abortion. [Tr. 251:10–15 (Ramesh)]. For patients who have a preference between medication and aspiration abortion, that preference is often strongly held. [Tr. 45:15–18 (Pasternack)].

19. For a medication abortion, a patient takes medications to end their pregnancy. [Tr. 251:10–12 (Ramesh)]. The most common form of medication abortion is a combination regimen of two medications: mifepristone and misoprostol. [Tr. 251:16–23 (Ramesh)]. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain pregnancy. [Tr. 251:19–21 (Ramesh)]. Misoprostol, typically taken zero to forty-eight hours later, causes the cervix to open and the uterus to contract and empty as it does during a miscarriage. [Tr. 251:21–23, 252:3–8 (Ramesh)].¹ The use of these medications to terminate a pregnancy requires no instruments, anesthesia, or

¹ It is also possible to terminate a pregnancy using misoprostol alone, which is also a safe and effective regimen. [Tr. 252:12–14, 252:22–253:8 (Ramesh)]. References to medication abortion used herein refer to the combination regimen of mifepristone and misoprostol.

sedation. [Tr. 252:9–11 (Ramesh)]. These drugs can also be used in a nearly identical manner to treat miscarriage. [Tr. 262:25–263:4 (Ramesh)].

20. The combination regimen of mifepristone and misoprostol was first approved by the U.S. Food and Drug Administration (“FDA”) in 2000. [Tr. 252:15–18 (Ramesh)]. At that time, the FDA authorized mifepristone’s provision by, or under the supervision of, physicians, and APCs could provide medication abortion so long as they did so under the supervision of a physician. [Tr. 253:9–22 (Ramesh)]. The FDA never required the supervising physician’s physical presence, and APCs have long provided medication abortion where allowed by state law. [Tr. 253:13–22 (Ramesh)]. In 2016, the FDA lifted the physician supervision requirement, allowing APCs to provide medication abortion fully independently. [Tr. 253:23–254:4 (Ramesh)]. The FDA issued further updates to its guidance on the use of mifepristone in January 2023, allowing medication abortion to be prescribed by mail. [Tr. 254:5–11 (Ramesh)].

21. Some patients need medication abortion because they are not eligible for an aspiration abortion based on medical contraindications, such as complex cardiac disease or a condition like uterine fibroids that makes it difficult to safely insert an instrument into the uterus. [Tr. 43:24–44:17 (Pasternack); 255:13-16, 259:10-19 (Ramesh)].

22. Some patients prefer medication abortion because they prefer to end their pregnancies in the comfort of their own home or another place of their choosing, surrounded by their chosen support people, if any, at a time that best fits with their work and family obligations. [Tr. 44:3–6, 44:9–12, 44:22–45:3 (Pasternack)]. To some, a medication abortion feels more natural—like a miscarriage. [Tr. 44:3–6 (Pasternack)].

For others, medication abortion can be a safer option because it allows a patient to disguise their abortion as a miscarriage; this is particularly important for patients who want to keep their abortion private from their partners, parents, family members, or others. [Tr. 256:21–257:6 (Ramesh)]. Some victims of rape or patients who have experienced sexual abuse or other trauma choose medication abortion to feel more in control of the experience and to avoid further trauma from having instruments placed in their vagina. [Tr. 256:10–20 (Ramesh)]. Other Planned Parenthood patients choose medication abortion because, especially since the Injunction, they can proceed more quickly than with aspiration abortion, in some cases receiving one the same day they become sure of their decision to obtain an abortion. [Tr. 44:22–45:3 (Pasternack)].

23. In a procedural abortion, a clinician uses instruments to end the pregnancy and empty the uterus. [Tr. 257:21–258:2 (Ramesh)]. During the first 15 weeks of pregnancy, patients are eligible for aspiration abortion. [Tr. 257:15–17 (Ramesh)]. After that point, they are eligible for a dilation and evacuation (“D&E”) abortion. [Tr. 257:17–20 (Ramesh)]. Both aspiration and D&E are forms of procedural abortion. [Tr. 251:12–15 (Ramesh)].

24. For an aspiration abortion, a clinician inserts a thin, flexible plastic tube into the patient’s uterus via the cervix and uses suction from a manual or electrical pump to remove the contents of the uterus. [Tr. 257:21–258:2 (Ramesh)]. Before beginning the aspiration procedure, the clinician gently dilates the cervix to access the uterus. [Tr. 257:23–25 (Ramesh)]. Aspiration abortion is not a form of surgery because it does not

involve incisions; instead, the tube is inserted through the natural openings of the vagina and cervix. [Tr. 259:5–9 (Ramesh)].

25. Some patients need an aspiration abortion because they are not eligible for medication abortion based on medical contraindications. These can include patients with intrauterine contraceptive devices (“IUDs”), known ectopic pregnancies, hemorrhagic disorders, anemia, or severe liver or kidney disease, or who are taking blood thinner medication. [Tr. 45:7–14 (Pasternack); 254:22–255:9 (Ramesh); 443:18–20 (Bender)].

26. Some patients prefer aspiration abortion to medication abortion. [Tr. 45:4–14 (Pasternack)]. For example, some are reassured by the presence of medical staff. [Tr. 260:8–260:19 (Ramesh)]. Others choose aspiration abortion because the procedure can be completed within one day, and they can be certain their pregnancies have ended by the time they leave the health center. [Tr. 260:8–19 (Ramesh)].

B. Abortion Is Very Safe.

27. Both medication and aspiration abortion are extremely safe, and both are safer than carrying a pregnancy to term. [Tr. 264:6–265:4, 269:13–18, 270:22–271:3 (Ramesh)].

28. Medication abortion is similar in risk to using common medications such as antibiotics or ibuprofen. [Tr. 264:16–23 (Ramesh)]. The risk of major complications from medication abortion is 0.31 percent. [Tr. 264:9–15 (Ramesh)]. The most common complications from medication abortion are excessive bleeding, incomplete abortion (meaning not all of the contents of pregnancy have been emptied from the uterus), continuing pregnancy (also called a failed abortion), and infection. [Tr. 265:5–12

(Ramesh)]. Complications typically occur after the patient has left the clinic, with the exception of an allergic reaction, which is extremely rare. [Tr. 463:10–22 (Bender)].

29. The risk of major complications from first trimester aspiration abortion is 0.16 percent. [Tr. 265:1–3 (Ramesh)]. The most common complications from aspiration abortion are excessive bleeding and infection. [Tr. 265:3–4 (Ramesh)]. The complications from aspiration abortion are nearly identical to those associated with aspiration for miscarriage. [Tr. 477:3–9 (Bender)].

30. When complications from medication or aspiration abortion occur, they can usually be managed with medications at home and/or an aspiration procedure. [Tr. 265:22–266:18 (Ramesh)].

31. Abortion is much safer than pregnancy. [Tr. 269:15–22 (Ramesh)]. Some of the most common pregnancy complications include urinary tract infections, hypertensive disorders, and mental health conditions. [Tr. 269:23–270:8 (Ramesh)]. Some common pregnancy complications, such as blood pressure and other cardiac issues, manifest later in pregnancy. [Tr. 270:11–21 (Ramesh)]. Thus, patients who terminate their pregnancies earlier do not encounter these complications. [Tr. 270:17–21 (Ramesh)].

32. Childbirth, which can require a Cesarean delivery (a major abdominal surgery), also carries greater risks than abortion. [Tr. 270:22–271:3–16 (Ramesh)].

33. Additional complications can begin after a patient has given birth, including wound complications, blood pressure issues, and postpartum depression. [Tr. 271:17–272:6 (Ramesh)].

34. Mortality rates for patients who carry their pregnancies to term are much higher than for abortion patients. [Tr. 272:7–11 (Ramesh)]. Maternal mortality rates are rising in Alaska and are twenty times higher than the mortality rate for abortion. [Tr. 272:7–17 (Ramesh)]. People living in rural or urban communities, people with lower socioeconomic statuses, Black women, and those with less access to prenatal or postnatal care are disproportionately affected by high maternal mortality rates. [Tr. 272:18–273:4 (Ramesh)].

35. Abortion is time-sensitive health care. [Tr. 46:2–3 (Pasternack)]. While abortion is incredibly safe, the risks increase with gestational age. [Tr. 46:5–10; 47:3–7 (Pasternack); 503:4–6 (Bender)]. As pregnancy progresses, in addition to the risk of complications from the pregnancy itself, the abortion procedure becomes more complex. [Tr. 46:2–10 (Pasternack); 305:10–24 (Ramesh)]. Thus, patients who are delayed in seeking abortion face increased medical risks than if they had obtained the abortion earlier. [Tr. 305:21–24 (Ramesh)].

III. Alaska APCs Can Provide Abortion as Safely as Physicians.

A. APC Scope of Practice and Provision of Care

36. APCs are a relatively new type of health care provider, emerging in the United States only in the 1960s. [Tr. 190:5–192:9 (Spetz)]. APCs hold advanced degrees and have rigorous licensing requirements. [Tr. 181:2–182:2, 191:7–192:9 (Spetz)]. In the past 30 years, states have moved towards affording APCs greater autonomy and practice authority. [Tr. 180:25–182:2, 185:3–186:7, 192:10–193:7, 198:13–199:23 (Spetz)]. Over half of states allow APRNs to practice without any formal arrangement with a physician.

[Tr. 193:8–15 (Spetz)]. This accords with evidence showing that APCs provide high-quality care, that their education prepares them to practice with a high degree of autonomy, and that unnecessary restrictions impede access to care. [Tr. 194:13–195:24 (Spetz)]. All major medical organizations agree that APCs provide high-quality, safe health care that is comparable to that provided by physicians. [Tr. 212:16–215:2 (Spetz)].

37. A health care provider’s scope of practice dictates what services they are permitted to provide patients. [Tr. 200:5-14 (Spetz); 353:1–3 (Bender)]. APCs’ scope of practice is regulated by state boards, including in Alaska, as well as by their individual knowledge and education. [Tr. 217:17–23 (Spetz); 353:7–13 (Bender)].

38. Today, throughout the United States including in Alaska, APCs can provide medical care autonomously and prescribe medications, including drugs like narcotics that carry greater risks than medication abortion. [Tr. 188:10–189:1 (Spetz); 279:22–280:11 (Ramesh)]. APCs are particularly critical in remote or rural health environments, including in Alaska, because they may be the only provider available and thus may be primarily responsible for administering or coordinating a wide range of health care. [Tr. 189:2–16 (Spetz); 273:18–274:18 (Ramesh)²]. APCs also provide the majority of women’s health care across the country. [Tr. 273:11–17 (Ramesh)].

39. The growth of the APC profession has led to increased access to care, particularly as APCs are more likely to practice in community health centers and in rural

² Referring to Alaska Div. of Pub. Health, *2021 Primary Care Needs Assessment*, at 33 (2021), https://alaskapca.org/wp-content/uploads/2021/05/SOA_PCO_NA_20211865-1.pdf.

settings. [Tr. 204:24–205:17, 206:15–207:24 (Spetz)]. APCs are also cost-effective; for example, states that allow APCs to practice autonomously have fewer emergency room visits. [Tr. 211:1–25 (Spetz)].

40. Absent state regulations to the contrary, abortion is within APCs’ scope of practice. [Tr. 351:20–352:8, 457:8–13 (Bender)]. APCs can provide both medication and aspiration abortions just as safely as physicians when offered proper training and when they work in a facility that supports them to provide abortion. [Tr. 281:2–282:9, 286:9–11 (Ramesh); 462:25–463:4, 478:19–479:6 (Bender)]. The risk of complications from an abortion is no greater when an APC performs an abortion than when a physician performs an abortion. [Tr. 281:2–282:8 (Ramesh); 462:25–463:4 (Bender)]. Major medical organizations including the National Academy of Medicine, the American College of Obstetricians and Gynecologists, the American Association of Public Health, the World Health Organization, the American College of Nurse Midwives, and the American Academy of Physician Assistants, endorse APC provision of abortion as within their area of competency. [Tr. 207:25–210:8 (Spetz); 282:10–25 (Ramesh)]. Furthermore, treating complications arising from abortion is also within APCs’ scope of practice, and APCs also provide this care. [Tr. 267:18–268:14 (Ramesh); 463:5–9, 23–24, 477:10–13 (Bender)].

41. APCs can legally provide medication abortion in 20 states and Washington, D.C., and aspiration abortion in 16 states and Washington, D.C. [Tr. 280:12–20 (Ramesh)]. The number of states that allow APCs to provide abortion has increased in

recent years based on the demonstrated safety of APC provision of abortion care. [Tr. 280:21–281:1 (Ramesh)].

42. Because APCs are more likely to provide medical care in rural and underserved communities, eliminating restrictions on APCs’ provision of abortion can expand abortion access, improve gynecological care generally, and promote continuity of care. [Tr. 298:5–299:11 (Ramesh)]. In health centers that already have physicians, permitting APCs to provide abortions expands the number of clinicians available for abortion services and thus expands the number and timing of available abortion appointments. [Tr. 300:16–301:8 (Ramesh)]. It further allows physicians to focus on more technically complex procedures and care. [Tr. 300:16–24 (Ramesh)].

43. By contrast, when APCs are barred from providing abortion, there are fewer providers, fewer available abortion appointments, and thus greater delays. [Tr. 299:12–22 (Ramesh)]. Patients have greater difficulty accessing abortion and may be past the gestational age limit for some methods of abortion or be unable to access abortion altogether. [Tr. 299:23–300:15 (Ramesh)].

44. The Alaska Board of Medicine and Board of Nursing recognize APCs’ scope of practice to be extremely broad. [Tr. 179:25–180:2, 201:23–202:7 (Spetz); 353:15–354:12 (Bender)]. Alaska was one of the first states to allow nurse practitioners to practice fully autonomously at the time of licensure; similarly, it allows PAs broad autonomy and practice authority. [Tr. 193:16–194:12 (Spetz)]. Alaska relies on APCs

more than most states, especially in rural areas. [Tr. 273:18–274:18 (Ramesh)³]. APCs in Alaska can perform many of the same tasks as licensed physicians, including examining, diagnosing, and treating patients, and prescribing and dispensing medical, therapeutic, or corrective measures.⁴

45. Pregnancy and childbirth, which are considered within APCs’ scope of practice, are commonly managed by APCs in Alaska: APCs provide routine prenatal care; screen for and diagnose serious pregnancy complications, like pre-eclampsia; manage vaginal deliveries; repair vaginal lacerations; and routinely manage serious complications such as postpartum hemorrhage. [Tr. 60:10–25, 61:10–20 (Pasternack); 278:12–279:21 (Ramesh); 355:22–356:9 (Bender)].⁵ Planned Parenthood’s APCs in Alaska also provide a broad range of reproductive health services, including preventative care, cancer screenings, annual exams, pap smears, STI screening, birth control visits, and ultrasounds. [Tr. 56:5–7, 59:9–12, 62:17–63:5 (Pasternack); 274:19–275:14 (Ramesh); 355:22–356:9, 456:11–457:2 (Bender)].

46. Abortion is the only medical procedure that is otherwise within their scope of practice that APCs are barred by law from performing in Alaska. [Tr. 80:6–13 (Pasternack); 204:16–23 (Spetz); 355:12–19 (Bender)].

³ Referring to Alaska Div. of Pub. Health, *2021 Primary Care Needs Assessment*, *supra* note 2, at 33.

⁴ AS 08.64.170 (physician assistants); 08.68.850 (advanced practice registered nurses).

⁵ APCs may consult physicians in providing these types of care and transition care to a physician if necessary; they are trained to and highly skilled at assessing when patients should be transitioned to a higher level of care. [Tr. 61:25–62:16 (Pasternack)].

B. Alaska APCs Are Qualified to Provide Abortion.

47. Absent the APC Ban, it would be within APCs' scope of practice to provide abortion in Alaska. [Tr. 80:1–13 (Pasternack); 444:15–17 (Bender)]. Planned Parenthood has policies and procedures in place to ensure competency in these skills and ensures that its clinical staff only provide care within the boundaries of their skills and training. [Tr. 49:3–50:15 (Pasternack); 345:13–19, 356:10–357:9, 441:22–445:5 (Bender)].

48. Even prior to the Injunction, Planned Parenthood's APCs provided all care leading up to the abortion and provided nearly all follow-up and treatment of complications. [Tr. 50:25–51:16 (Pasternack); 449:12–17 (Bender)]. APCs educate patients and obtain their consent, do their medical screenings, and conduct ultrasounds to identify patients with contraindications for medication abortion. [Tr. 445:6–446:2, 446:23–451:5 (Bender)] .

49. Since the Injunction, APCs have been providing nearly all medication abortions. *See* [Tr. 74:21–75:3 (Pasternack)]. Because Planned Parenthood's APCs were already extensively trained, some required only minimal additional training and were able to begin providing medication abortion in as little as 24 hours after the Injunction. [Tr. 454:5–454:11 (Bender)].

50. Meanwhile, Planned Parenthood's complication rate from medications abortions has remained low. Since the Injunction, there have not been any complications out of the ordinary from when physicians were providing medication abortions, nor have any complications required hospitalization. [Tr. 75:25–76:12 (Pasternack); 467:18–468:4 (Bender)].

51. Planned Parenthood’s APCs are also trained to manage these potential risks and complications, and, even before the Injunction, provided the majority of this care.⁶ [Tr. 463:5–9 (Bender)]. They are more likely than Planned Parenthood’s physicians to be called upon to manage complications because they are at the health centers more frequently. [Tr. 463:5-9, 463:23–464:16 (Bender)]. They also are involved in triaging patient concerns, providing follow-up treatment, and evaluating and referring for a higher level of care as necessary if patients call Planned Parenthood’s 24 hour hotline with concerns after an abortion. [Tr. 266:19–267:1 (Ramesh); 465:10–466:13 (Bender)]. This safety protocol is the same regardless of whether an APC or a physician provides the abortion. [Tr. 468:5–9 (Bender)].

52. Treatment of certain abortion complications is medically identical to medication and aspiration abortion. For example, if a patient has excessive bleeding and cramping following a medication abortion, an APC can assess a possible incomplete abortion with an ultrasound and treat it with medication or aspiration, comparable to how medication or aspiration could be administered for miscarriage or abortion. [Tr. 52:17–53:25 (Pasternack); 263:5–12 (Ramesh)]. There is no difference in skill or training

⁶ One of the few complications APCs could not treat prior to the Injunction was failed medication abortion, meaning the patient’s pregnancy continued. *See supra* ¶ 28. Because the pregnancy has continuing cardiac activity, APCs could not provide an additional dose of medication abortion to complete the abortion prior to the Injunction. [Tr. 54:7–24 (Pasternack)]. With the Injunction, Planned Parenthood APCs now treat this complication with medication. [Tr. 54:25–55:4 (Pasternack)]. There is no distinction in treatment for failed medication abortion and an incomplete abortion. *Compare* [Tr. 54:17–20 (Pasternack)] *with* [Tr. 52:24–53:4 (Pasternack)].

needed to provide these treatments for incomplete abortion as compared to using these treatments for abortion. [Tr. 263:5–264:5 (Ramesh)].

53. The same treatments can also be used for miscarriage. [Tr. 59:9–60:3 (Pasternack); 261:24–262:8 (Ramesh); 356:15–357:9, 460:9–13 (Bender)]. The doses and medication used for miscarriage management are the same as those most commonly used for medication abortion. [Tr. 59:19–22 (Pasternack); 262:17–24 (Ramesh); 451:6–19, 452:7–15 (Bender)]. Providing these medications requires the same skills, knowledge, and training whether they are used for miscarriage management or medication abortion. [Tr. 60:14–18 (Pasternack); 262:25–263:4 (Ramesh)]. Aspiration provided for miscarriage is also medically identical to aspiration abortion and requires the same skills and training. [Tr. 60:19–22 (Pasternack); 460:2–8, 459:21–460:13 (Bender)].

54. APCs in Alaska are legally able to treat miscarriage with medications or with aspiration, and it is within their scope of practice to do so.⁷ [Tr. 52:6–54:6 (Pasternack)]. However, due to the APC Ban, it is not feasible to train APCs to provide any form of aspiration (including for miscarriage or to address complications from abortion). [Tr. 53:21–25, 369:17–370:25 (Pasternack); 504:9–23 (Bender)]. Because the APC Ban prevents APCs from performing aspiration abortions and because there is a relatively low volume of miscarriage and incomplete abortion patients treated with aspiration, APCs seeking to train to perform aspiration would need to go out of state to gain sufficient

⁷ As Ms. Bender testified, the Board of Nursing does not currently have a policy prohibiting aspiration for miscarriage. *See* [Tr. 354:23–355:15, 460:18–22 (Bender)].

hands-on training. *Id.* Accordingly, Planned Parenthood’s APCs do not currently provide aspiration. [Tr. 53:21–25, 368:21–22 (Pasternack)].

55. But prior to the Injunction, if a Planned Parenthood APC saw a miscarrying patient who chose medical management, the APC could provide that care. [Tr. 59:13–22 (Pasternack); 452:16–24 (Bender)]. However, if a patient in the next room wanted an abortion using the same medications, the APC could not administer the same exact treatment to that patient, and if a physician was not available, the abortion patient would have to come back to the clinic on another day. [Tr. 452:25–453:10 (Bender)].

56. In addition to treating abortion complications and miscarriage, APCs in Alaska routinely provide care that is similar in risk and complexity to providing abortion and that utilizes some of the same skills as providing abortion. For example, APCs treat patients for ectopic pregnancies using methotrexate,⁸ provide prophylactic treatment for HIV, insert and remove IUDs,⁹ and provide gender-affirming care. [Tr. 62:17–63:5 (Pasternack); 274:19–276:1 (Ramesh); 454:12–457:2 (Bender)]. These treatments are similar to or more complex than medication abortion. [Tr. 454:17–455:1, 455:20–456:3 (Bender)].

⁸ Methotrexate is a chemotherapy agent or immunosuppressant that stops a pregnancy from growing and is administered via injection to patients with a confirmed ectopic pregnancy. [Tr. 455:2–14]. Medication abortion is considered safer than methotrexate. [Tr. 455:15–19].

⁹ Inserting or removing an IUD is similar to aspiration, whether performed for miscarriage or abortion, because the clinician may have to visualize and dilate the patient’s cervix and insert instruments into the uterus, through the cervix, using ultrasound guidance, [Tr. 276:2–9 (Ramesh); 455:20–456:3 (Bender)]; *see also* [Tr. 444:1–14] (Ms. Bender described how she would treat a “particularly difficult IUD insertion”).

57. There is no medical reason why APCs at Planned Parenthood should not continue to provide medication abortion. [Tr. 63:6–8 (Pasternack); 457:3–7 (Bender)].

58. Furthermore, there is also no reason why, if properly trained, APCs could not start providing aspiration abortion. [Tr. 63:9–11 (Pasternack); 462:6–9 (Bender)]. To provide aspiration, clinicians need skills in using suction to remove pregnancy contents. [Tr. 457:14–25 (Bender)]. These are skills that APCs can easily acquire, and APCs currently provide care that is comparable to or more complex than aspiration, including intrauterine insemination, endometrial biopsies,¹⁰ vasectomies, loop electrosurgical excision procedures (“LEEPs”),¹¹ perform endometrial ablation,¹² colposcopies, and colonoscopies. [Tr. 274:19–278:11 (Ramesh); 458:1–459:20 (Bender)].

59. The APC Ban’s effect is therefore to restrict the field of qualified professionals who are willing and able to provide abortion in Alaska without enhancing patient safety, [Tr. 39:25–40:18 (Pasternack); 248:10–19 (Ramesh)], and it is out of step with the way Alaska regulates clinicians with regard to all other services, [Tr. 215:12–16 (Spetz)].

¹⁰ Endometrial biopsy involves inserting a thin, flexible plastic tube to take a sample of the uterine lining. [Tr. 276:10–13 (Ramesh)]. It is performed to evaluate abnormal bleeding and to diagnose endometrial cancer. [Tr. 456:4–10 (Bender)]. Performing an endometrial biopsy involves the same technique as aspiration but with a different sized tube. [Tr. 276:14–18 (Ramesh)].

¹¹ LEEPs involve removing a portion of the cervix after an abnormal pap smear by using a thin wire loop with electricity in it. [Tr. 277:7–10 (Ramesh)].

¹² Endometrial ablation involves putting a catheter into the uterus to treat abnormal bleeding. [Tr. 277:11–18 (Ramesh)].

IV. The APC Ban Burdens Patients Seeking Abortion in Alaska by Unnecessarily Reducing the Pool of Qualified Health Care Professionals Who Can Provide that Care.

A. The APC Ban Is a Constraint on Abortion Appointments.

60. In Alaska, the APC Ban reduces the availability of abortion care, including by limiting the number of days Planned Parenthood can offer abortion services. [Tr. 40:2-11 (Pasternack)].

61. Because of the APC Ban, Planned Parenthood was forced to rely on per diem physicians to provide all abortions prior to the Injunction. [Tr. 35:10-13, 50:21-24, 55:9-14, 63:19-21 (Pasternack)].

62. Prior to the Injunction, Planned Parenthood’s per diem physicians offered medication abortion approximately one to two times per week at each clinic, depending on physician availability, including by telemedicine.¹³ Ex. 1022; [Tr. 50:21-24, 64:21-67:7 (Pasternack); 479:20-480:17 (Bender)]. There were specific days when abortion was expected to be available, though the schedule varied depending on physicians’ schedules and their other professional commitments. [Tr. 480:18-481:4 (Bender)].

63. As noted above *supra* ¶ 49, since the Injunction, all of Planned Parenthood’s APCs have begun providing medication abortion.¹⁴ Ex. 1021; [Tr. 63:15-18, 68:19-69:2

¹³ When providing care through telemedicine, Planned Parenthood generally utilizes a “site-to-site” model, meaning that the provider is at one Planned Parenthood health center while the patient is at another Planned Parenthood health center. [Tr. 65:6-66:23 (Pasternack)]. Planned Parenthood’s provision of medication abortion one or two times a week at each health center included by telemedicine. [Tr. 65:22-66:2 (Pasternack)].

¹⁴ Since the Injunction, Planned Parenthood’s physicians rarely provide medication abortion and are instead able to focus on performing procedural abortions and addressing complex gynecological issues. [Tr. 74:21-75:24 (Pasternack)].

(Pasternack); 488:21–23, 498:4–8 (Bender)]. As a result, each Planned Parenthood clinic can offer medication abortion every day it is open.¹⁵ Ex. 1022; [Tr. 64:11–20, 67:13–21, 69:3–70:13 (Pasternack)].

64. Because of the APC Ban, Planned Parenthood is still only able to offer aspiration abortion through 13.6 weeks once per month¹⁶ in Juneau and Fairbanks, and procedural abortion through 17.6 weeks once per week in Anchorage, because those are the days on which it is able to staff per diem physicians. [Tr. 45:23–46:1, 67:8–12, (Pasternack)].

65. The table below shows Planned Parenthood’s aspiration abortion schedule and how the ability to provide medication abortion on more days has changed due to the Injunction:

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¹⁵ The days each clinic is open have not changed: the Juneau clinic is open Tuesday through Thursday; the Fairbanks clinic is open Tuesday through Friday; and the Anchorage clinic is open Monday through Friday and two Saturdays a month. [Tr. 64:11–20 (Pasternack)].

¹⁶ At times in the past, Planned Parenthood was able to provide aspiration abortion once or twice per month in Fairbanks based on physician availability. [Tr. 480:4–8 (Bender)].

| | Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. |
|--|--|-------|-------------------------|---------|------|------|
| Juneau | | | | | | |
| <u>Medication abortion (“MAB”) before Injunction</u> | ½ day once per week, including via telehealth* | | | | | |
| <u>MAB since Injunction</u> | | Yes | Yes | Yes | | |
| <u>Aspiration</u> | | | 3d Wed. of each month* | | | |
| Fairbanks | | | | | | |
| <u>MAB before Injunction</u> | ½ day once per week, including via telehealth* | | | | | |
| <u>MAB since Injunction</u> | | Yes | Yes | Yes | Yes | |
| <u>Aspiration</u> | | | 1st Wed. of each month* | | | |
| Anchorage | | | | | | |
| <u>MAB before Injunction</u> | ½ day once per week, including via telehealth* | | | | | |
| <u>MAB since Injunction</u> | Yes | Yes | Yes | Yes | Yes | Yes |
| <u>Procedural</u> | | | | Weekly* | | |

* dependent on physician availability

Ex. 1022; [Tr. 64:11–66:2, 66:25–67:21, 69:9–70:13 (Pasternack)].

66. The effect of the Injunction has been to give patients who are seeking medication abortions greater scheduling flexibility. [Tr. 498:9–13 (Bender)].

67. Since the Injunction, the number of medication abortions provided by Planned Parenthood has increased. In the year preceding the Injunction compared to the year following the Injunction, medication abortions increased by approximately 33 percent. Exs. 1000–1003, 1020; [Tr. 70:18-74:14 (Pasternack)].

68. Since the Injunction, patients have also been able to obtain abortions, including aspiration abortions, earlier in their pregnancies, and the clinicians who testified at trial noted that fewer patients had been pushed beyond the age limit for a medication abortion in that time period.¹⁷ [Tr. 94:7–20 (Pasternack); 500:1–21 (Bender)].

69. Because of limited physician availability, patients needing an aspiration abortion still face delay in scheduling appointments. [Tr. 501:13–17, 502:3–503:3, 503:13–25 (Bender)].¹⁸

¹⁷ Ms. Bender could not recall any patients since the Injunction who had been pushed past the gestational age limit for medication abortion, whereas before this happened “not infrequently.” [Tr. 500:1–21 (Bender)]. Dr. Pasternack recalled one patient, who faced barriers in traveling to the health center and had to cancel many appointments with Planned Parenthood. [Tr. 94:14–20 (Pasternack)].

¹⁸ Patients seeking aspiration for miscarriage face similar barriers due to the logistical challenges the APC Ban poses for APCs seeking to train to provide that care, even though they are legally able to do so. *Supra* ¶ 54. Extending the length of time between a miscarriage and an aspiration can increase the risk of infection. [Tr. 504:1–8 (Bender)].

B. Limited Appointment Availability Burdens Patients Financially, Logistically, Physically, and Emotionally.

1. General Effects of Limited Appointment Availability

70. There can be no doubt that the APC Ban's drastic impact on the days on which patients can obtain an abortion adds an additional barrier to care. [Tr. 488:23–489:1 (Bender)]. When abortion clinics are forced to offer abortion services on a limited basis, someone who is unable to take off school or work on the particular day of the week that an abortion can be provided is likely to be delayed or prevented from obtaining an abortion. [Tr. 301:9–303:22 (Ramesh)]. The limit on abortion availability caused by the APC Ban is especially harmful because people seeking abortions are more likely to be low-income and have limited transportation, inflexible job schedules, or caregiving responsibilities, all of which constrain their ability to travel and thus to schedule an abortion even further. [Tr. 301:11–17 (Ramesh)]. Many Planned Parenthood patients must pay for travel and childcare and take time off work to get an abortion. [Tr. 91:22–92:4, 106:18–19, 431:14–432:15 (Pasternack)]. All of these costs increase when patients must travel farther to access an abortion, further delaying access to care. [Tr. 47:12–15, 91:7–10, 91:22–92:4 (Pasternack); 296:6–13, 300:5–15, 303:4–22 (Ramesh)]. For example, patients who were once candidates for aspiration may be pushed past the gestational age limit in Juneau or Fairbanks and have to travel to Anchorage as opposed to using a clinic closer to their home. [Tr. 502:23–503:3 (Bender)].

71. At minimum, any delay in the ability to reach a health center can cause a scheduled abortion appointment to have to be rescheduled for a week or more. *See, e.g.,*

infra ¶¶ 94–95. Delays are also compounded if patients need to return to the health center. For example, if a patient comes in for a medication abortion but needs an aspiration abortion—perhaps because they are further along in their pregnancy than anticipated—and cannot receive that care from an APC, they will need to come back to the clinic on a day when a physician is present. [Tr. 500:22–501:17 (Bender)]. These delays put patients at greater risk of being unable to access abortion in Alaska altogether due to gestational age limits. *Id.*

72. However, when abortion is available on every day the health center is open, then delay for a personal or travel-related reason may result in the abortion being rescheduled for just a day or two later than originally planned. [Tr. 301:11–302:11 (Ramesh)].

73. As a result of delays, some patients age out of the time for a medication abortion, or may age out of the time for an abortion altogether. [Tr. 493:4–13, 496:2–6 (Bender)]. Some patients may receive a different type of care than they would have preferred. [Tr. 496:2–8 (Bender)]. If a patient needs or prefers to have a medication abortion for medical reasons, the patient who is delayed in accessing an appointment because of the limited appointments available may be precluded altogether from having an abortion or may face increased medical risk when having a procedural abortion. [Tr. 44:3–17 (Pasternack); 255:10–20 (Ramesh)]. If a patient whose closest health center is in Juneau or Fairbanks is pushed past 13.6 weeks of pregnancy, the patient will need to travel—if they are able—to Anchorage to obtain an abortion. [Tr. 47:12–15 (Pasternack); 303:23–304:1 (Ramesh); 502:23–503:3 (Bender)]. If a patient is pushed past 17.6 weeks,

they will need to leave Alaska altogether—if they are able—to obtain an abortion. [Tr. 46:21–47:2 (Pasternack); 495:24–496:2 (Bender)]. Though abortion is legally available in other states beyond 17.6 weeks of pregnancy, travel out of state is both more expensive and more time-consuming than obtaining an abortion within Alaska. [Tr. 46:24–47:2 (Pasternack); 495:24–496:2 (Bender)]; *supra* ¶ 70. In other words, these patients’ ability to obtain an abortion is delayed and sometimes denied because abortion cannot be performed by the full spectrum of qualified and available health care providers. [Tr. 501:10–502:2 (Bender)].

74. For any patient, delay means the patient is forced to stay pregnant for longer than they otherwise would have, with all of the attendant risks of pregnancy. *See supra* ¶ 31. Some, who cannot obtain an abortion at a time and place they can access, are forced to continue a pregnancy that they otherwise would not have chosen to continue. [Tr. 493:4–13 (Bender)]. Continuing a pregnancy has medical consequences. For example, first trimester pregnancy symptoms, including nausea and vomiting, may impact people’s abilities to complete work or home tasks. [Tr. 46:2–17 (Pasternack); 304:7–15 (Ramesh)]. Also, patients diagnosed with cancer or other serious diseases may want to get an abortion as soon as possible so they can proceed with their treatment. [Tr. 47:16–48:1 (Pasternack)]. Similarly, simply being pregnant is not medically safe for some, such as patients with severe heart disease. [Tr. 48:2–6 (Pasternack)].

75. Moreover, patients who want to terminate a pregnancy typically do not obtain prenatal care. [Tr. 305:25–306:4 (Ramesh)]. Thus, a person who wanted an abortion but is ultimately unable to access abortion and is forced to carry the pregnancy

to term can face medical consequences resulting from the lack of early prenatal care, including increased risks of preterm birth and complications after delivery. [Tr. 305:25–306:23 (Ramesh)]. People who want an abortion but are forced to carry their pregnancies to term face socioeconomic consequences, including being less likely to bring themselves and their families out of poverty, continue working, or finish school. [Tr. 307:8–14 (Ramesh)].

76. Delay in obtaining an abortion can be psychologically and physically harmful and can remove patient autonomy. [Tr. 304:7–20 (Ramesh); 493:21–494:9 (Bender)]. When people decide that they want an abortion and are firm in their decision, they generally would like to get that abortion as soon as they are able. [Tr. 305:4–9 (Ramesh); 486:17–23 (Bender)]. For example, patients who became pregnant as a result of an assault face particular trauma when forced to extend an unwanted pregnancy. Delay in the ability to access an abortion may also increase the difficulty of keeping a pregnancy confidential. [Tr. 304:20–23 (Ramesh)]. This can pose a particular danger for people in intimate partner violence relationships, who face an increased risk of violence during pregnancy. [Tr. 304:24–305:3 (Ramesh); 486:8–13 (Bender)]; *see also infra* ¶ 87. Being forced to wait to terminate a pregnancy can cause distress and anxiety. [Tr. 46:11–20, 126:8–10 (Pasternack)]. People who are unable to access abortion in a clinical setting may attempt to self-induce an abortion, which can carry medical risks. [Tr. 306:24–307:7 (Ramesh); 493:21–494:9 (Bender)].

77. Limited appointment availability also compromises privacy for those who wish not to have family, friends, or employers learn of their decision to have an abortion,

including adolescents and people experiencing intimate partner violence. [Tr. 448:17–24, 496:9–497:12, 693:2–17 (Bender)]. Abortion is a sensitive topic, and many people prefer to keep their decision private. [Tr. 496:4–5 (Bender)]. Because a medication abortion will generally result in bleeding and cramping, the APC Ban, by limiting the days when abortions are available, limits the ability of patients to control when that bleeding and cramping occurs. [Tr. 496:21–497:3 (Bender)]. The APC Ban deprives those patients of their privacy and autonomy. [Tr. 496:9–497:12 (Bender)].

78. The APC Ban disrupts continuity of care and bars patients from seeing a provider of their choosing. [Tr. 286:2–287:1 (Ramesh)]. Prior to the Injunction, APCs provided every aspect of medication abortion care short of handing over the medications to the patient. [Tr. 50:25–51:16 (Pasternack)]. Patients at Planned Parenthood expressed frustration that they could not receive their abortion from their preferred provider—the APC who had already counseled them and with whom they had established a relationship. [Tr. 449:12–17, 660:2–11 (Bender)]. Many of these patients would have preferred to receive care sooner from the APC who was already treating them and with whom they had already shared their personal and medical history. [Tr. 485:4–486:13 (Bender)].

79. The State has contended that Planned Parenthood’s wait time data, which shows the length of time between the date a patient made an appointment and the date they received an abortion, indicates that the APC Ban does not delay Alaskans seeking abortion because wait times went up following the Injunction. *See* Exs. M (Resp. to Interrogatory No. 7), T–V. However, the wait time data does not reflect the overall delays patients encounter because they do not reflect when patients first contact Planned

Parenthood to inquire about appointment times or delays due to a patient’s schedule as they may need to make arrangements to take time off work or for childcare, or later to reschedule. Ex. M (Resp. to Interrogatory No. 7). Nor does it account for changes in clinic staffing. [Tr. 331:11–12 (Ramesh)]. The APC Ban compounds these delays by restricting the days on which abortion is offered. *See supra* ¶¶ 60–62, 64–65, 69. Furthermore, the wait time data does not distinguish between medication and procedural abortions. *See* Exs. M, T–V.

2. The APC Ban’s Effect on People Who Live in Rural Areas

80. The APC Ban disproportionately impacts Alaskans living in rural areas. Because Planned Parenthood only has health centers in Anchorage, Fairbanks, and Juneau, Alaskans living outside of those cities are not in geographic proximity to abortion providers and may have to travel long distances to access services.¹⁹ [Tr. 41:9–11 (Pasternack)]. Eighty percent of Alaska’s rural communities are not on the main road system or only have seasonal access to road systems. [Tr. 613:1–4 (Johnson)]. To access abortion, Alaskans living in those communities generally have to fly to a hub community and from there to a population center, such as Anchorage. These flights can cost several hundred dollars each. [Tr. 611:5–13 (Johnson)]. Additionally, people traveling to access abortion may also face childcare costs, the logistical and financial burden of bringing their children with them, and the cost of staying overnight in the place they access abortion. [Tr. 611:14–21 (Johnson)]; *see also supra* ¶ 70.

¹⁹ Most women’s health care providers do not provide abortions including because of stigma, harassment, and threats. [Tr. 294:3–19, 295:3–17 (Ramesh)].

81. In Alaska, weather often curtails people’s ability to travel, affecting both the road systems and air travel. [Tr. 492:13–493:3 (Bender); 613:8–16 (Johnson)]. For example, flights can be delayed by as much as a week. [Tr. 614:1–10 (Johnson)]. When rural patients with limited access to travel that is subject to severe weather are also limited in the number of days abortion is available, they are even more susceptible to extended delays in receiving care. [Tr. 616:17–618:17 (Johnson)].

3. The APC Ban’s Effect on Victims of Intimate Partner Violence

82. Planned Parenthood routinely sees patients in intimate partner violence relationships or who are victims of assault who express concern about their physical and emotional states when forced to delay their abortions until a physician is available. [Tr. 486:8–13 (Bender)].

83. Intimate partner violence is very common in Alaska, with over half of women in Alaska experiencing it in their lifetime. [Tr. 579:23–580:2 (Johnson)]. It disproportionately affects women, people in lower socioeconomic strata, and American Indian and Alaska Native women. [Tr. 580:3–5, 582:18–583:6, 602:21–23, 603:15–604:4 (Johnson)].

84. Intimate partner violence includes physical violence, sexual violence, and psychological aggression. [Tr. 581:14–582:17 (Johnson)]. Victims can, and often do, experience more than one form of abuse—called polyvictimization. [Tr. 588:10–19 (Johnson)].

85. One type of psychological aggression is coercive control and entrapment, which involves controlling and monitoring what one’s intimate partner does. [Tr. 581:24–

582:2, 580:13–20; 583:15–17 (Johnson)]. It includes dictating who the partner can associate with and where they can go and controlling the partner’s access to money. [Tr. 583:15–19 (Johnson)]. Within their lifetime, 21 percent of Alaska women have had partners try to limit their contact with family or friends, 18 percent have had partners try to prevent them from leaving the house, 28 percent have had partners who kept track of them by demanding to know where they were and what they were doing, and 19 percent have had partners threaten self-harm or suicide. [Tr. 600:1–21 (Johnson)].

86. One type of coercive control and entrapment is reproductive control, when a partner controls the other’s choices around reproductive health, including whether to become pregnant or have a child and whether to use contraceptives. [Tr. 584:12–16, 584:25–585:4 (Johnson)]. Reproductive control can also include forcing a partner either to have or not to have an abortion. [Tr. 585:5–8 (Johnson)]. It puts victims at risk for unintended pregnancy and sexually transmitted infections. [Tr. 585:12–17 (Johnson)]. Six percent of Alaska women have had partners who tried to get them pregnant when they did not want to become pregnant or who tried to prevent them from using birth control. [Tr. 600:22–601:6 (Johnson)].

87. Pregnancy increases the risk of homicide in general, including by an intimate partner. [Tr. 586:11–20 (Johnson)]. Pregnancy and having a child can also make it more difficult for victims to leave an abusive relationship. [Tr. 586:21–588:9 (Johnson)]. For people experiencing intimate partner violence, obtaining an abortion can decrease the violence they experience, whereas being unable to obtain an abortion can increase the physical violence they experience. [Tr. 585:18–586:10, 631:11–24 (Johnson)].

88. The lack of flexibility in scheduling an abortion due to the APC Ban and the resulting increased likelihood of delay in obtaining an appointment mean that people in a relationship marked by intimate partner violence are exposed to more opportunities for their abusers to discover their pregnancies and/or abortion-seeking efforts. [Tr. 618:18–619:14 (Johnson)].

89. People experiencing intimate partner violence have to overcome a number of barriers in order to obtain an abortion. [Tr. 602:1–603:14 (Johnson)]. Those experiencing coercive control and entrapment must evade their partner’s surveillance. [Tr. 602:15–18 (Johnson)]. To do so, they may need an alibi, or an alternative explanation, for their whereabouts. [Tr. 612:15–22 (Johnson)]. They may also have to overcome constrained economic means, whether because they are low income or because their partner is controlling their money. [Tr. 602:19–23, 603:8–14 (Johnson)]. Because abusers often isolate their victims from friends and families, people experiencing intimate partner violence may have limited support systems that could otherwise help them obtain an abortion, including by helping them with childcare, transportation, a place to stay, or an alibi. [Tr. 602:23–603:7 (Johnson)].

90. Victims of intimate partner violence also face travel-related barriers in seeking abortion, including related to surveillance. [Tr. 605:3–13 (Johnson)]. Even adding just minutes to the length of time it takes for someone experiencing intimate partner violence to receive a needed service, including abortion, reduces the likelihood they will be able to access that service. [Tr. 605:25–606:1 (Johnson)].

91. These barriers are particularly acute for people in rural areas experiencing intimate partner violence, who have to travel long distances to access abortion. [Tr. 608:2–11, 608:16–21 (Johnson)]. Because of dense social networks in rural communities, people experiencing intimate partner violence encounter difficulties seeking help in obtaining abortion services while keeping their pregnancies concealed from their abusers. [Tr. 609:1–24, 611:22–612:22 (Johnson)]. The travel barriers described *supra* ¶¶ 80–81 apply to and are exacerbated for people experiencing intimate partner violence living in rural areas. [Tr. 577:20–578:8, 614:17–24 (Johnson)]. Due to the distance and time necessary for travel, coming up with an alibi for abortion-related travel can be particularly difficult for people living in rural areas. [Tr. 614:25–615:14 (Johnson)]. Some try to make their trip coincide with other medical care or a major cultural event in order to keep their abortion private from an abusive partner. [Tr. 615:15–616:12 (Johnson)].

92. Providing a reason for traveling would be difficult if the day on which abortion was available did not coincide with a plausible reason for traveling to the urban center. [Tr. 617:1–22 (Johnson)]. The weather would also need to cooperate to ensure they were able to make the trip. [Tr. 617:23–618:2 (Johnson)]. Any disruptions meant starting the process of getting away anew. [Tr. 617:23–618:17 (Johnson)].

93. These obstacles to obtaining an abortion for a person in an abusive relationship living in rural Alaska were particularly hard to overcome before the Injunction when Planned Parenthood was only able to offer medication abortion services once each week. [Tr. 616:17–618:17 (Johnson)]. They continue to be a burden for people seeking aspiration abortion. *See id.; supra* ¶¶ 64–65, 69.

4. The APC Ban's Effect on People Seeking Abortions in Fairbanks and Juneau

94. The APC Ban is particularly harmful for those whose nearest clinic is not Anchorage. For example, patients in need of aspiration abortion and whose nearest provider is in Fairbanks are particularly impacted by the APC Ban. Because Planned Parenthood is only able to offer aspiration abortion through physicians once per month in Fairbanks, a patient may have to wait close to four weeks to receive an aspiration abortion. [Tr. 92:13–20 (Pasternack)]. This delay can put a patient past the gestational age limit for aspiration abortion (and thus for abortion in Fairbanks), or if a patient is unable to travel to obtain an abortion, it can prevent the patient from obtaining an abortion altogether. [Tr. 91:14–18 (Pasternack)]; *see also supra* ¶ 71. While it is possible to travel to Anchorage, doing so is expensive, and patients may encounter travel delays, including due to weather. [Tr. 91:22–92:4 (Pasternack)].

95. The APC Ban is also particularly harmful for the Juneau clinic's patients. Because, like Fairbanks, aspiration abortion is only offered once each month, a patient may have to wait close to four weeks to receive an aspiration abortion. *See supra* ¶¶ 64–65, 94; [Tr. 502:23–503:3 (Bender)]. Juneau has a large transient population, particularly in the summer, including people who work on cruise boats, seasonal workers, and tourists passing through for a short period of time. [Tr. 82:23–83:71 (Pasternack); 490:2–16 (Bender)]. In the summer of 2023 alone, Planned Parenthood had four transient patients seek aspiration abortions in Juneau on a day when a physician was not scheduled to be in the clinic. [Tr. 84:15–18 (Pasternack)]. While in the past, Planned Parenthood has been

able to accommodate these patients by having a physician come in for a single patient, even when the patients' time in Juneau does not align with the one day per month when the Juneau health center normally provides aspiration abortion. [Tr. 83:18–84:2 (Pasternack)]) Planned Parenthood's ability to do this relies on physician availability, and patients could encounter a scenario where neither of the two physicians in Juneau is available to provide abortion during the patient's brief period in Juneau, especially if APCs are no longer able to provide medication abortion. *See* [Tr. 83:25–84:11 (Pasternack)].

96. It is often not feasible for these patients to travel to Anchorage for abortion services because of the expense, the short window they are in Juneau, and the fact that it is not possible to fly back and forth to Anchorage in one day, and because some are cruise ship employees who need to stay with their ships. [Tr. 85:22–86:11, 83:3–7 (Pasternack)].

5. The APC Ban's Effect on People Who Learn They Are Pregnant at a Non-Abortion Appointment

97. A patient may learn that they are pregnant at a non-abortion appointment and know that they want an abortion, or decide to choose abortion while they are at an appointment scheduled to confirm their pregnancy and gestational age and to discuss their options. [Tr. 481:8-23, 662:12-664:13 (Bender)]. Prior to the Injunction, these patients would have to return to the clinic for another appointment unless they happened to be at the clinic on a day when a physician was at the center and had the time to perform a previously unscheduled abortion. [Tr. 76:22–77:7, 105:20–106:10 (Pasternack); 481:5–23 (Bender)]. Sometimes, the next available appointment sometimes was not for up to

two weeks. [Tr. 483:18–483:4 (Bender)]. This could and did push patients outside of the window for medication abortion; it also pushed some patients outside the eligibility window for any abortion in the State of Alaska. [Tr. 486:24–487:10 (Bender)].

98. Patients who discovered they were pregnant at a non-abortion appointment and were firm in their decision to proceed with an abortion but were unable to do so became upset, frustrated, or panicked. [Tr. 482:7–14 (Bender)]. They expressed a range of concerns that might prevent them from coming back to the clinic for another appointment, including inability to arrange childcare or transportation and weather, particularly if there was a snowstorm on the horizon. [Tr. 484:23–485:22 (Bender)].

99. Patients also expressed concern for their privacy. This was especially true for patients with inflexible work schedules, as well as for victims of assault or those experiencing intimate partner violence. [Tr. 485:23–486:13 (Bender)].

100. Even after the Injunction, patients who learn they are pregnant at non-abortion appointments and choose or need an aspiration continue to suffer these delays and other harms. *See supra* ¶ 69.

V. How a Permanent Injunction Would Affect Abortion Patients in Alaska

101. A permanent injunction would allow APCs to continue offering medication abortions every day that the clinics are open, affording patients greater flexibility to schedule their abortion on a day that best meets their needs and life circumstances and reducing delays and patient burdens, including those caused by severe weather and other problems with travel. [Tr. 498:9–499:14 (Bender)]. For example, patients who find out that they are pregnant at a non-abortion appointment and know that they want an abortion

will be able to exercise their constitutional right without delay. [Tr. 488:14–20; 499:15–25 (Bender)].

102. If APCs were able to provide aspiration, Planned Parenthood would be able to provide aspiration abortion more often, which would allow patients to obtain earlier abortions, give physicians greater ability to treat patients needing later abortions, and reduce barriers to care. [Tr. 94:21–24 (Pasternack); 504:24–505:12 (Bender)].

103. All of Planned Parenthood’s APCs are interested in providing aspiration abortion, and if the APC Ban were permanently enjoined, they could begin training to do so. Ex. 1021; [Tr. 77:13–19; 92:21–93:25 (Pasternack)].

104. This would increase the availability of aspiration abortion in Juneau and Fairbanks, reducing the need to travel for many patients and benefiting transient patients seeking abortions in Juneau. *See supra* ¶¶ 94–96.

105. A permanent injunction would also benefit patients seeking aspiration for miscarriage, who currently face similar barriers to care as patients seeking aspiration for miscarriage. While APCs are legally permitted to provide aspiration for miscarriage management, it is not operationally feasible for Planned Parenthood to train its APCs to do so because of the APC Ban. *Supra* ¶ 54. Because the training for aspiration abortion and aspiration for miscarriage is identical, if the APC Ban were lifted APCs would be able to complete that training by treating aspiration abortion patients in Alaska. [Tr. 53:21–25, 60:4–22 (Pasternack); 459:21–462:5 (Bender)].

106. For all these reasons, enjoining the APC Ban would increase access to abortion (as well as miscarriage management) and reduce patient burdens.

107. The experience in Virginia demonstrates the benefits of allowing APCs to provide medication and aspiration abortion. As Dr. Ramesh testified, since Virginia legalized APC provision of abortion in July 2020, APCs have provided both medication and aspiration abortion. [Tr. 283:1–12 (Ramesh)]. The Planned Parenthood affiliate providing abortions in Virginia has been able to provide abortion appointments on additional days of the week and during a greater number of hours, including evening and weekend hours. [Tr. 283:13–285:1, 292:13–18 (Ramesh)]. They are able to see patients sooner, and it is easier for their patients to schedule an abortion around their work and childcare obligation. [Tr. 292:25–293:7 (Ramesh)]. APC provision of abortion has enhanced continuity of care. [Tr. 298:21–299:11 (Ramesh)]. The Virginia clinics are now able to fit in more abortion patients on short notice, which is particularly important when patients are close to a gestational age cut-off. [Tr. 292:13–293:7 (Ramesh)]. By using APCs to perform most abortions, the Virginia clinics see a greater number of abortion patients in a day, and physicians are able to focus on providing later abortion care and complex gynecological care. [Tr. 283:1–286:1, 288:3–11 (Ramesh)].

108. However, if APCs were no longer able to provide any type of abortion in Alaska, including medication abortion, patient access to abortion would decrease. Patients would likely need to travel further to access care and would likely access care later, in addition to experiencing less autonomy over their decision to end their pregnancies, loss of privacy, additional expenses, and other harms. [Tr. 505:13–506:11 (Bender)].

CONCLUSIONS OF LAW

I. The APC Ban Infringes Alaskans’ Fundamental Right to Privacy.

109. The Alaska Constitution, article I, section 22, expressly protects a fundamental right to privacy that includes “personal autonomy and independence in decision making.”²⁰ This right extends to the ability of individuals to make their own reproductive choices.²¹ The Alaska Constitution is more protective of individual privacy rights than the federal Constitution, even prior to the United States Supreme Court’s decision in *Dobbs v. Jackson Women’s Health Organization*, 597 U.S. 215 (2022).²²

110. While statutes are presumed to be constitutional, those “infringing on a constitutionally protected right deserve[] close attention,”²³ and “the State bears a high burden to justify’ such laws.”²⁴

111. “[F]ew things [are] more personal than one’s body. . . .”²⁵ Therefore Alaskans’ right to privacy and autonomy, including the right to an abortion, “may be

²⁰ *Doe v. Dep’t of Pub. Safety*, 444 P.3d 116, 127 (Alaska 2019); see also SJ Order at 12.

²¹ *Valley Hosp. Ass’n v. Mat-Su Coal. for Choice*, 948 P.2d 963, 969 (Alaska 1997); SJ Order at 14–15 (“The fundamental [right to privacy] includes decisional autonomy—the right to reproductive choice, and bodily autonomy—the right to access abortion care.” (citing *Planned Parenthood of the Great Nw. v. State*, 375 P.3d at 1139 (Alaska 2016) (“*Planned Parenthood IV*”) and *State v. Planned Parenthood of Alaska*, 35 P.3d 30, 40 (Alaska 2001) (“*Planned Parenthood II*”))).

²² *Mat-Su Coal.*, 948 P.2d at 968.

²³ *Planned Parenthood IV*, 375 P.3d at 1133.

²⁴ *State v. Planned Parenthood of the Great Nw.*, 436 P.3d 984, 1000 (Alaska 2019) (“*Planned Parenthood V*”) (quoting *State, Dept. of Health & Soc. Servs. v. Planned Parenthood of Alaska*, 28 P.3d 904, 912 (Alaska 2001) (“*Planned Parenthood I*”)).

²⁵ *Breese v. Smith*, 501 P.2d 159, 169 (Alaska 1972).

legally constrained only when the constraints are justified by a compelling state interest, and no less restrictive means could advance that interest.”²⁶

112. For strict scrutiny to be warranted, the challenged restriction must “constrain[],”²⁷ “impos[e] a burden on,”²⁸ or “interfere[] with”²⁹ the right in question. Regulations do this not only when they “prohibit the [abortion] decision entirely”³⁰ but also when they compromise the private nature of the patient’s decision and when they threaten the relationship between a patient and their health care provider.³¹ The current case law’s treatment of the exact showing required to meet this threshold is cursory, but it is clear that the burden is not high and that, in the privacy context, it does not require

²⁶ *Mat-Su Coal.*, 948 P.2d at 968; *see also Planned Parenthood IV*, 375 P.3d at 1134 (“The privacy clause guarantees that the State may not infringe upon an individual’s fundamental right of personal autonomy unless a compelling governmental interest justifies the infringement. . . .”); *Breese*, 501 P.2d at 170–71 (“Once a fundamental right under the constitution of Alaska has been shown to be involved and it has been further shown that this constitutionally protected right has been impaired by governmental action, then the government must come forward and meet its substantial burden of establishing that the abridgment in question was justified by a compelling governmental interest.”); SJ Order at 13.

²⁷ *Mat-Su Coal.*, 948 P.2d at 968.

²⁸ *Carey v. Pop. Servs. Int’l*, 431 U.S. 678, 686 (1977); *see also State v. Planned Parenthood of Alaska*, 171 P.3d 577, 582 (Alaska 2007) (“*Planned Parenthood III*”); *State v. Ostrosky*, 667 P.2d 1184, 1193 (Alaska 1983).

²⁹ *Mat-Su Coal.*, 948 P.2d at 971; *Zablocki v. Redhail*, 434 U.S. 374 (1978); *Fraternal Order of Eagles v. City & Borough of Juneau*, 254 P.3d 348, 355 (Alaska 2011).

³⁰ *Carey*, 431 U.S. at 688.

³¹ *Mat-Su Coal.*, 948 P.2d at 968 n.8; *see also Carey*, 431 U.S. at 688–89 (considering a regulation requiring contraceptives to be distributed by licensed pharmacists and finding that “substantially limit[ing] access to the means of effectuating [the private] decision” by restricting “distribution channels [for contraceptives] to a small fraction of the total number of possible retail outlets renders contraceptive devices considerably less accessible to the public[and] reduces the opportunity for privacy of selection and purchase”).

that abortions have been delayed or prevented. Moreover, the inquiry focuses on the extent of the barrier to the individuals who are affected, not on how many people are affected.³²

113. In *Mat-Su Coalition*, for example, the Alaska Supreme Court applied strict scrutiny in a challenge to a single, 36-bed hospital’s policy declining to provide abortions outside of narrow fetal anomaly and medical emergency exceptions based on a moral stance against abortion. The Court found that the policy sufficiently implicated privacy and personal autonomy rights because it could threaten the relationship between a patient and their health care provider, despite citing no patients to whom this had happened.³³ Notably the policy did not prevent patients from going to a different hospital. Further, the Court did not find it necessary to interrogate or quantify the policy’s impact on abortion access or ask whether specific individuals would be burdened or delayed in accessing abortion before striking it down because, like here, there was no asserted “medical, safety, or other public-welfare interest” in the policy.³⁴

114. Similarly, in *Planned Parenthood III*, the Court applied strict scrutiny to a parental consent statute without any threshold analysis of whether minors who did not wish, or were unable to, obtain parental consent would be able to utilize the statute’s judicial bypass procedures or would be delayed by them. Again there was no fact-

³² See *Planned Parenthood II*, 35 P.3d at 35 (“The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant.” (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 894 (1992), overruled on other grounds by *Dobbs*, 597 U.S. 215).

³³ *Mat-Su Coal.*, 948 P.2d at 968 n.8.

³⁴ *Id.* at 971.

intensive examination at the outset of how the parental consent statute would affect minors' ability to get abortions.³⁵ The Court simply noted that the statute "requires minors to secure either the consent of their parent or judicial authorization before they may exercise their uniquely personal reproductive freedoms," and that this "no doubt place[d] a burden on minors' fundamental right to privacy."³⁶

115. Here, too, every patient's right to privacy and autonomy is constrained when state action deprives them of access to the full range of medical professionals qualified and able to provide abortion because the State has inserted itself into patients' decision of when, whether, and how to obtain an abortion.³⁷

116. At any rate, even if, as the State has argued, some higher showing of impairment were required to trigger strict scrutiny, Planned Parenthood has made it. As described above, the APC Ban effectively constrains the number of days that Planned Parenthood can offer abortion. Before the Injunction, Planned Parenthood was only able to offer medication abortion about once per week at each of its health centers, including

³⁵ The Court did appropriately consider the burdens imposed by the law, including by the judicial bypass procedure, in its inquiry into whether the law was narrowly tailored to further the State's compelling interest. *Planned Parenthood III*, 171 P.3d at 584. However, the State has not argued that there is any compelling interest here. *See infra* ¶¶ 123, 137.

³⁶ *Planned Parenthood III*, 171 P.3d at 582.

³⁷ *See Planned Parenthood II*, 35 P.3d at 38 (describing the right to privacy as "the people's right to privacy from unwarranted governmental intrusion"); *cf. Carey*, 431 U.S. at 689 (applying strict scrutiny and striking down a challenged regulation requiring contraceptives to be distributed by licensed pharmacists because "the restriction of distribution channels [for contraceptives] to a small fraction of the total number of possible retail outlets renders contraceptive devices considerably less accessible to the public, reduces the opportunity for privacy of selection and purchase, and lessens the possibility of price comp").

by telemedicine, and to offer aspiration abortion as infrequently as once a month due to physician availability. *Supra* ¶¶ 62, 64–65. Since the Injunction, Planned Parenthood can offer medication abortion every day that its health centers are open, and the number of medication abortions has increased; aspiration appointments could also be expanded if not for the APC Ban. *Supra* ¶¶ 63, 65, 67, 102–04.

117. As Planned Parenthood witnesses testified, limited appointment availability delays and prevents patients from accessing abortion care, *supra* ¶¶ 69, 70–71; can compromise patients’ privacy by making it more difficult to keep their decision confidential and by removing patients’ ability to choose when to experience the bleeding and cramping of a medication abortion, *supra* ¶¶ 76–77; can increase medical risks, *supra* ¶¶ 74–75; can prevent patients from obtaining an abortion by their chosen method, despite what are often deeply held preferences, *supra* ¶¶ 18, 43, 70–71, 73, 94; and can impose additional costs in terms of travel expenses, lost wages, and childcare, among others, that patients can ill afford, *supra* ¶¶ 70, 80, 91, 94, 96, 98. These effects of limited abortion scheduling are felt by all patients but especially by patients who are low-income, have inflexible job schedules, have caretaking responsibilities, or have limited access to transportation, especially because weather can have a significant impact on one’s ability to access time-sensitive care. *Supra* ¶¶ 70, 80. The APC Ban also imposes heavy burdens on people who live in rural areas, victims of intimate partner violence, adolescents, patients accessing abortion outside of Anchorage, and people who learn that they are pregnant at non-abortion appointments and are firm in their decision to have an abortion.

Supra ¶¶ 76–77, 80–100. Enjoining the APC Ban will increase the availability of abortion appointments and will thus reduce these burdens.

118. This evidence, taken together, proves that the APC Ban imposes a burden on Alaskans’ reproductive rights.

119. That ends the court’s analysis. The State here has asserted no justification at all for the APC Ban, much less a compelling one. In doing so, it has effectively conceded that the APC Ban fails strict scrutiny, should the court find this to be the applicable level of review.³⁸

120. Even if the court concludes that strict scrutiny does not apply, the APC Ban still fails to pass constitutional muster. Under any applicable tier of review, a law that has no justification necessarily fails.³⁹ The State has never argued that the APC Ban is rooted in concerns over maternal health or safety. Indeed, these purposes are *contravened* by the APC Ban. *See supra* ¶¶ 36, 38–43. APCs can provide medication abortion and aspiration—and since the Injunction have been providing medication abortion—just as safely and effectively as physicians and doing so is within their scope of practice. *Supra* ¶¶ 40–41, 49–50. Planned Parenthood’s APCs already provide the majority of care in the

³⁸ *See Mat-Su Coal.*, 948 P.2d at 968 n.8 (striking down abortion policy that lacked justification); *cf. Planned Parenthood II*, 35 P.3d at 39 (rejecting test that would allow the State to “restrict privacy for non-compelling reasons or, potentially, for no reason at all.”).

³⁹ *Cf. Concerned Citizens of S. Kenai Peninsula v. Kenai Peninsula Borough*, 527 P.2d 447, 452 (Alaska 1974) (“Substantive due process is denied when a legislative enactment has no reasonable relationship to a legitimate governmental purpose.”); *Doe*, 444 P.3d at 126.

clinics, including care that is just as, if not more, complex than abortion. *Supra* ¶¶ 3, 56, 58.

121. The court denied Planned Parenthood’s motion for summary judgment based on disputes of fact for two reasons. First, it cited the weight and credibility of Planned Parenthood’s evidence, including the credibility of Dr. Pasternack and Ms. Bender.⁴⁰ At trial, both Planned Parenthood providers demonstrated their credibility,⁴¹ including through the depth of their knowledge about the population of people seeking abortions in Alaska and the barriers to accessing this care. *Supra* ¶¶ 9–10, 14. That Dr. Pasternack and Ms. Bender cannot identify specific patients who were unable to, or delayed in, accessing care or quantify the number of patients harmed by the APC Ban does not undermine their credibility, particularly in light of the fact that they are qualified experts in the provision of abortion in Alaska. Second, the court relied on the expert report of Dr. Michael J. New. SJ Order at 18. However, at trial, the State presented no testimony from Dr. New—or indeed any witness. These issues must now be resolved in Planned Parenthood’s favor.

⁴⁰ SJ Order at 16–18.

⁴¹ It is the province of the superior court to determine witness credibility, including “overlook[ing] inconsistencies and contradictions in testimony where the weight of the evidence counsels the court to do so.” *Matter of Quade M.*, No. S-17503, 2021 WL 1832146, at *4 & n.18 (Alaska May 5, 2021) (quoting *Gold Dust Mines, Inc. v. Little Squaw Gold Mining Co.*, 299 P.3d 148, 166-67 (Alaska 2012)) (affirming credibility finding of Garton, J.).

122. Because the APC Ban restricts access to abortion and is not narrowly tailored and necessary to any compelling state interest, it violates Alaskans’ fundamental right to privacy and reproductive freedom and must be permanently enjoined.

II. The APC Ban Infringes Alaskans’ Right to Equal Protection.

123. The Alaska Constitution “mandates ‘equal treatment of those similarly situated.’”⁴² Alaska’s equal protection clause is more protective than its federal counterpart.⁴³

124. Alaska courts apply a three-step equal protection analysis, using a “sliding scale.”⁴⁴ The first step is to “determine[] at the outset what weight should be afforded the constitutional interest impaired by the challenged enactment.”⁴⁵ Second, courts examine the purpose served by a challenged statute. “Depending on the level of review determined, the state may be required to show only that its objectives were legitimate, at the low end of the continuum, or, at the high end of the scale, that the legislation was motivated by a compelling state interest.”⁴⁶ Finally, courts evaluate the relationship between the state’s interest and the means used to further this purpose. “At the low end of the sliding scale, we have held that a substantial relationship between means and ends

⁴² *Planned Parenthood I*, 28 P.3d at 909; Alaska Const., art. 1, § 1; SJ Order at 20.

⁴³ *Planned Parenthood I*, 28 P.3d at 909.

⁴⁴ *State v. Erickson*, 574 P.2d 1, 11–12 (Alaska 1978).

⁴⁵ *Planned Parenthood V*, 436 P.3d at 1001.

⁴⁶ *Id.*

is constitutionally adequate.”⁴⁷ But, at the opposite end, “the fit between means and ends must be much closer.”⁴⁸

125. “When equal protection claims are raised, the question is whether two groups of people who are treated differently are similarly situated and therefore are entitled to equal treatment under the constitution.”⁴⁹ “To determine whether the [challenged law] discriminates between similarly situated classes,” courts first assess “which classes must be compared.”⁵⁰

126. Here, there are two pertinent comparisons for an equal protection analysis: (1) pregnant patients seeking abortion and pregnant patients seeking other types of pregnancy-related medical care, *see* SJ Order at 20–21; and (2) APCs and physicians.

A. The APC Ban Unconstitutionally Discriminates between Pregnant Patients Seeking Abortion and Pregnant Patients Seeking Other Pregnancy-Related Care.

127. The APC Ban treats pregnant patients seeking abortion differently from pregnant patients seeking other types of pregnancy-related medical care. As this court recognized, “[t]he classification imposes different burdens on pregnant patients based on their decisions whether to terminate or continue their pregnancies.”⁵¹ The APC Ban

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Planned Parenthood IV*, 375 P.3d at 1135 (quoting *Pub. Emps. Ret. Sys. v. Gallant*, 153 P.3d 346, 349 (Alaska 2007)).

⁵⁰ *Id.* 1135–36.

⁵¹ SJ Order at 21; *see also Planned Parenthood IV*, 375 P.3d at 1142 (“‘Until actually seeking pregnancy-related medical care the only difference between’ pregnant people seeking an abortion and pregnant people seeking to carry their pregnancy to term ‘is the constitutionally protected choice each is making.’”).

requires something more onerous of a patient seeking an abortion than it does of other pregnant patients: that they seek care from a physician, where such care is significantly less available than care available from APCs, who are equally qualified to provide abortions. By contrast, patients seeking care for continuing their pregnancy may find an appointment with the full range of qualified providers, including APCs.

128. The equal protection clause “guarantees that the State may not discriminate between individuals with respect to a fundamental right unless a compelling governmental interest justifies the discrimination.”⁵² As the Alaska Supreme Court has made clear, “[a] woman who carries her pregnancy to term and a woman who terminates her pregnancy exercise the same fundamental right to reproductive choice.”⁵³ “Alaska’s equal protection clause does not permit governmental discrimination against either woman,” and “both must be granted access to state health care under the same terms as any similarly situated person.”⁵⁴

129. Because the APC Ban discriminates with respect to a fundamental right, it should be reviewed under strict scrutiny.⁵⁵ “Such scrutiny is particularly called for where, as in this instance, the rejection of one option [(abortion)] inevitably requires the other”⁵⁶

⁵² *Planned Parenthood IV*, 375 P.3d at 1134.

⁵³ *Planned Parenthood V*, 436 P.3d at 1000 (quoting *Planned Parenthood I*, 28 P.3d at 913). While *Planned Parenthood V* addressed state-funded care, a similar analysis applies when the state imposes an obstacle only to medical care to end a pregnancy, but not to continue it.

⁵⁴ *Id.* (quoting *Planned Parenthood I*, 28 P.3d at 913).

⁵⁵ *Id.* at 1001 (“[I]t has long been established that a law burdening the fundamental right of reproductive choice demands strict scrutiny.” (quoting *Planned Parenthood IV*, 375 P.3d at 1137–38)).

⁵⁶ *Id.*

(continued pregnancy). For this level of scrutiny to apply, “[t]he challenged legislation need not expressly forbid the exercise of the right”; it is enough that the government “by selectively denying a benefit to those who exercise a constitutional right, effectively deters the exercise of that right.”⁵⁷ Proof of actual deterrence is not necessary; a showing of objective deterrence is sufficient.⁵⁸ Another way of framing the objective deterrence requirement is to consider “the degree to which the challenged law can be said to *penalize* exercise of the right.”⁵⁹

130. Planned Parenthood has more than met its burden of showing that the APC Ban penalizes those who exercise their right to abortion. The APC Ban denies pregnant patients the benefit of accessing only abortion from the full range of qualified providers, while granting this benefit to those seeking all other forms of pregnancy-related care. Put another way, it imposes an extra requirement on—or penalizes—pregnant people seeking abortion as opposed to those seeking other pregnancy-related care (i.e., that they must see a physician for this care, as opposed to any qualified health care provider).

⁵⁷ *Id.* (second quoting *Planned Parenthood I*, 28 P.3d at 909); *see also id.* at 1003 (“Disparate restrictions on government funding for women based on their choice of either abortion or childbirth deter the exercise of a fundamental right because pregnant women in that position are locked in a binary dilemma: the rejection of one option inevitably entails the embrace of the other.”).

⁵⁸ *Alaska Pac. Assur. Co. v. Brown*, 687 P.2d 264, 271 n.11 (Alaska 1984) (“There is no requirement to demonstrate actual deterrence of the right to travel in state or federal law.”); *see also Planned Parenthood I*, 28 P.3d at 909; SJ Order at 21 (“This does not require proof of actual deterrence; ‘the relevant criteria are the fact and severity of the restriction.’” (quoting *Alaska Pac. Assur. Co.*, 687 P.2d at 271 n.11)).

⁵⁹ *Alaska Pac. Assur. Co.*, 687 P.2d at 271 (emphasis added).

131. That the APC Ban discriminates against Alaskans seeking abortion, but not other forms of pregnancy care, is most pronounced when observing miscarriage care, which is largely identical to abortion. As Ms. Bender testified at trial, before the Injunction, if she were seeing a patient for an unrelated service and that patient presented with a miscarriage, she could treat the miscarriage herself, during the very same appointment. *Supra* ¶ 55. If, however, the patient in the next room learned they were pregnant at an unrelated appointment and was firm in their decision to proceed with an abortion, she could not treat that patient, and that patient would have to return to the clinic if a physician were not available that day. *Id.* This impediment is still in place for patients who prefer or require an aspiration abortion.

132. Similarly, patients seeking non-abortion pregnancy-related care are not subject to the additional barrier the APC Ban creates to accessing care in Alaska of limited appointment availability. *Compare supra* ¶¶ 45, 52 *with supra* ¶¶ 60, 62, 65, 67. They can better schedule their appointments for prenatal care around their work schedules, their caregiving responsibilities, their ability to travel, and the weather. *See supra* ¶¶ 66, 70.

133. The State has put forth no justification for treating pregnant patients seeking abortion worse than those who do not wish to exercise this right. Without any purpose at all furthered by the APC Ban, the court need not advance to the second or third steps of

the equal protection analysis. The APC Ban therefore undoubtedly fails strict scrutiny review.⁶⁰

B. The APC Ban Unconstitutionally Discriminates Between APCs and Physicians, Who Are Similarly Situated for Purposes of Providing Abortion.

134. Similarly, the APC Ban uniquely denies APCs, but not physicians, the ability to provide care that is within their scope of practice, even though APCs and physicians are similarly situated for purposes of providing abortion.⁶¹

135. Undisputed evidence establishes that abortion is within APCs' scope of practice, just as it is within a physician's, and that APCs, with the appropriate training and support, can provide abortion just as safely as physicians. *Supra* ¶¶ 40, 47, 50. Throughout the entirety of this case, the State has acknowledged that the APC Ban treats APCs and physicians differently by restricting the type of care APCs can provide and has conceded that APCs can provide this care as safely and effectively as physicians. But the State has put forth no justification for this disparate treatment or explained why abortion is the only type of care singled out by Alaska law while, in every other setting, it recognizes APCs' broad scope of practice.⁶² *Supra* ¶¶ 44, 46. An APC who wishes and

⁶⁰ Even if the Court finds that the burdens created by the classification are not sufficient to trigger strict scrutiny, the ban fails under any level of review for the reasons discussed *infra* ¶ 136.

⁶¹ Where, as here, the classifications are defined by the statute, it is a question of law as to whether the groups are similarly situated. *Planned Parenthood V*, 436 P.3d at 1000; *Planned Parenthood IV*, 375 P.3d at 1135–37.

⁶² *Cf. Planned Parenthood V*, 436 P.3d at 1135 (“In order to determine whether differently treated groups are similarly situated, we look to the state’s reasons for treating the groups differently.” (quoting *Planned Parenthood IV*, 375 P.3d at 1135)).

is otherwise qualified to provide abortion is categorically prohibited from doing so just because they are an APC, whereas a physician is not so prohibited. The only possible reason for this facial discrimination⁶³ is to burden abortion (as compared to other pregnancy care) by constraining which practitioners can provide it.

136. For these reasons, the Court should find that the APC Ban violates the equal protection clause. Where the State has proffered absolutely no relationship between means and ends, it cannot satisfy even the rational basis test.⁶⁴ Even “at the low end of the sliding scale,” the State must still show “a substantial relationship between means and ends.”⁶⁵ The State has wholly failed to satisfy this requirement.

CONCLUSION

137. For the foregoing reasons, Planned Parenthood requests that the court declare AS 18.16.010(a)(1) unconstitutional and enter a permanent injunction against its enforcement as applied to advanced practice clinicians.⁶⁶

⁶³ *Planned Parenthood IV*, 375 P.3d at 1135–36.

⁶⁴ *Cf. Erickson* (noting that the rational basis standard in Alaska is more stringent than its federal counterpart); *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 448 (1985) (holding that additional permit requirement for a residence for people with disabilities failed rational basis review where there was no reason to believe that the home “would pose any special threat to the city’s legitimate interests”). Planned Parenthood has not argued that there is a right to provide abortion in Alaska.

⁶⁵ *Planned Parenthood V*, 436 P.3d at 1001.

⁶⁶ In the alternative, if the court finds that Planned Parenthood has not carried its burden with respect to aspiration abortion, Planned Parenthood asks that it permanently enjoin the APC Ban as applied to medication abortion. The evidence is clear that the law significantly burdens access to medication abortion by artificially constraining the number and frequency of available appointments, whereas since the Injunction, Planned Parenthood has been able to offer medication abortion via APCs every day its health centers are open, and the number of medication abortions since the Injunction has increased.

138. The court should declare Planned Parenthood the prevailing party in this constitutional litigation and set a schedule for its application for an award of full, reasonable attorney fees.

Dated this 26TH day of January 2024.

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CERTIFICATE OF SERVICE

This certifies that on January 26, 2024, a copy of the foregoing was served via email on:

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