ALASKA STATE LEGISLATURE
HOUSE JUDICIARY STANDING COMMITTEE
May 9, 2002
4:12 p.m.

MEMBERS PRESENT

Representative Norman Rokeberg, Chair
Representative Jeannette James
Representative John Coghill
Representative Kevin Meyer
Representative Ethan Berkowitz
Representative Albert Kookesh

MEMBERS ABSENT

Representative Scott Ogan, Vice Chair

OTHER LEGISLATORS PRESENT

Representative Fred Dyson
Representative Andrew Halcro

COMMITTEE CALENDAR

SENATE BILL NO. 364
"An Act relating to medical services under the state Medicaid program."

- HEARD AND HELD

PREVIOUS ACTION

BILL: SB 364
SHORT TITLE:MEDICAID PAYMENTS FOR ABORTIONS
SPONSOR(S): RLS BY REQUEST

Jrn-Date	Jrn-Page		Action
04/18/02	2840	(S)	READ THE FIRST TIME - REFERRALS
04/18/02	2841	(S)	FIN
04/23/02		(S)	FIN AT 9:00 AM SENATE FINANCE 532
04/23/02		(S)	-- Meeting Canceled --
04/23/02		(S)	FIN AT 4:00 PM SENATE FINANCE 532
04/23/02		(S)	Moved Out of Committee

04/23/02		(S)	MINUTE(FIN)
04/24/02	2920	(S)	FIN RPT 5DP 2DNP 1NR
04/24/02	2920	(S)	DP: KELLY, GREEN, OLSON, LEMAN, WARD;
04/24/02	2920	(S)	DNP: DONLEY, AUSTERMAN; NR: WILKEN
04/24/02	2920	(S)	FN1: INDETERMINATE(HSS)
05/01/02		(S)	RLS AT 10:30 AM BELTZ 211
05/01/02		(S)	-- Location Change --
05/01/02		(S)	MINUTE(RLS)
05/06/02	3182	(S)	RULES TO CALENDAR 1OR 5/6/02
05/06/02	3185	(S)	READ THE SECOND TIME
05/06/02	3186	(S)	ADVANCED TO 3RD READING FLD Y13 N6 E1
05/06/02	3186	(S)	ADVANCED TO THIRD READING 5/7 CALENDAR
05/07/02	3208	(S)	READ THE THIRD TIME SB 364
05/07/02	3208	(S)	PASSED Y12 N7 E1
05/07/02	3208	(S)	ELLIS NOTICE OF RECONSIDERATION
05/08/02	3221	(S)	RECON TAKEN UP - IN THIRD READING
05/08/02	3221	(S)	PASSED ON RECONSIDERATION Y12 N8
05/08/02	3244	(S)	TRANSMITTED TO (H)
05/08/02	3244	(S)	VERSION: SB 364
05/09/02	3460	(H)	READ THE FIRST TIME - REFERRALS
05/09/02	3460	(H)	JUD, FIN
05/09/02		(H)	JUD AT 4:00 PM CAPITOL 120

WITNESS REGISTER

GWENDOLYN HALL, Staff
to Senator Pete Kelly
Alaska State Legislature
Capitol Building, Room 518
Juneau, Alaska 99801
POSITION STATEMENT: Presented SB 364 on behalf of Senator Kelly, who was the requestor SB 364, which was sponsored by the Senate Rules Committee.

SENATOR PETE KELLY
Alaska State Legislature
Capitol Building, Room 518
Juneau, Alaska 99801

POSITION STATEMENT: Testified as the requestor of SB 364, which was sponsored by the Senate Rules Committee.

KIRSTEN BEY, Member
Board of Directors
Alaska Civil Liberties Union (AkCLU)
PO Box 667
Nome, Alaska 99762
POSITION STATEMENT: During discussion of SB 364, provided comments in opposition.

DEATRICH SITCHLER
520 Glacier Bay Circle
Anchorage, Alaska 99508
POSITION STATEMENT: Testified against SB 364.

ROBIN SMITH
14100 Jarvi Drive
Anchorage, Alaska 99515
POSITION STATEMENT: Testified in opposition to SB 364.

KATHLEEN G. TODD, M.D.
Valdez Medical Clinic
PO Box 1829
Valdez, Alaska 99686
POSITION STATEMENT: Her testimony opposing SB 364 was read by Robin Smith.

PAULINE UTTER
13820 Jarvi Drive
Anchorage, Alaska 99515
POSITION STATEMENT: Testified in opposition to SB 364.

JAN WHITEFIELD, M.D.
Alaska Women's Health Services, Inc.
4115 Lake Otis Parkway
Anchorage, Alaska 99508
POSITION STATEMENT: Her testimony opposing SB 364 was read by Pauline Utter.

LEILA WISE
(No address provided)
POSITION STATEMENT: Testified in opposition to SB 364.

JOHN MIDDAUGH, M.D., Chief
Epidemiology Section
Division of Public Health

Department of Health & Social Services (DHSS)
PO Box 240249
Anchorage, Alaska 99524-0249
POSITION STATEMENT: Testified in opposition to SB 364.

LISA VILLANO
PO Box 751655
Fairbanks, Alaska 99775
POSITION STATEMENT: Testified in opposition to SB 364.

KRISTEN BOMENGEN, Assistant Attorney General
Human Services Section
Civil Division (Juneau)
Department of Law (DOL)
PO Box 110300
Juneau, Alaska 99811-0300
POSITION STATEMENT: Provided comments during discussion of SB 364.

COLLEEN M. MURPHY, M.D., Obstetrician-Gynecologist
3260 Providence Drive
Anchorage, Alaska 99508
POSITION STATEMENT: Testified in opposition to SB 364.

CHIP WAGONER
Alaska Catholic Conference
3294 Pioneer Avenue
Juneau, Alaska 99801
POSITION STATEMENT: Testified in support of SB 364.

SIDNEY HEIDERSDORF, Alaskans For Life, Inc.
PO Box 20874
Juneau, Alaska 99802
POSITION STATEMENT: Testified in support of SB 364.

ACTION NARRATIVE

TAPE 02-61, SIDE A
Number 0001

CHAIR NORMAN ROKEBERG called the House Judiciary Standing Committee meeting to order at 4:12 p.m. Representatives Rokeberg, James, Coghill, and Meyer were present at the call to order. Representatives Berkowitz and Kookesh arrived as the meeting was in progress.

SB 364 - MEDICAID PAYMENTS FOR ABORTIONS

Number 0012

CHAIR ROKEBERG announced that the committee would hear SENATE BILL NO. 364, "An Act relating to medical services under the state Medicaid program."

Number 0082

GWENDOLYN HALL, Staff to Senator Pete Kelly, Alaska State Legislature, testified on behalf of Senator Kelly, who was the requestor SB 364, which was sponsored by the Senate Rules Committee. She remarked that it was Senator Kelly's intention to define "medically necessary" with regard to state-funded Medicaid abortions. She said:

> Right now there is almost an epidemic of elective abortions' being funded with state monies even though the court case of Perdue versus Planned Parenthood [State Dept. of Health & Social Services v. Planned Parenthood of Alaska, et al. (07/27/2001) sp-5443] states that only medically necessary abortions will be paid with state funds. What this bill does is, just defines medically necessary so we know exactly what we're talking about. There's been accusations and claims that there is no proof that elective abortions are being paid for with state monies, and since we don't have in law yet that all abortions need to be reported, we can only use data from previous years. And in 1997, there were 1079 abortions paid for with state Medicaid monies, and they have these codes, which were kind of confusing, on the left-hand column - and I'm sorry, I didn't provide you with copies of this ... - that diagnose what each medical procedure is.
>
> And if you look through the "Professional for Physicians, Volumes 1 and 2," you can find reference to what these codes are. And for "legal abortion, uncomplicated" - obviously, those are without medical necessary reasons - and then right below that is unwanted pregnancy - that's without medical reasons. Then you have legally induced abortions, and with that code you'll find: without specific complications. And so that right there is proof in the pudding that the state is paying for elective abortions. This bill isn't planning on making abortion illegal; ... it

> wasn't introduced to take away medical procedures for indigent women of Alaska. It's just making sure that we are abiding by the Planned Parenthood versus Perdue [State Dept. of Health & Social Services v. Planned Parenthood of Alaska, et al. (07/27/2001) sp-5443] case, and only paying for medically necessary abortions.

MS. HALL, in response to a question, said that last year, 577 abortions were paid by Medicaid.

Number 0409

SENATOR PETE KELLY, Alaska State Legislature, speaking as the requestor of SB 364, which was sponsored by the Senate Rules Committee, said that abortions are paid with Medicaid match money. In response to a question, he said:

> Federal dollars are not used to pay for abortions other than those that fall under the "Hyde Amendment," which can be paid for by Medicaid. The state uses money that we would have matched against Medicaid, but we choose not to fund more of the health issues with them; we fund the abortions under ... Medicaid match. It used to be under general relief medical; that program was ended, and now ... we just use Medicaid match (indisc.).

SENATOR KELLY, in response to another question, said:

> We match Medicaid money with general fund ... money when the services are performed. If we don't ever take that match money and pay for services with it, it never gets ... in the Medicaid pot, so to speak; it can be diverted for other purposes. The court has done that to pay for state funded abortions. Once it's matched ... for a Medicaid service, it can't be used to pay for abortions except those under the Hyde Amendment. I don't know the exact number of those, but those are very few.

CHAIR ROKEBERG asked, "So there's matching federal and state dollars under our ratio that pays for Hyde Amendment abortions, is that correct?"

SENATOR KELLY said:

> Yes, Mr. Chairman, those pay for a lot of other medical services as well. As I said, I don't know the exact number of Medicaid abortions; those are very few, and if ... [there] are any at all, and there are a couple of them, they are for those that fall under the Hyde Amendment. The ones that we do under state regulations are not paid for with Medicaid money; they're paid for with other money - state money.

Number 0565

CHAIR ROKEBERG said he has concerns because even in the aforementioned case, "[Chief] Justice Fabe very clearly states that these payments are not to be made for elective abortions, and that's not the issue here.

SENATOR KELLY said:

> The problem is, is that elective abortions are a matter of the regulations. That's the purpose of the bill.... Medically necessary abortions are ones that would affect the life and health of the mother. However, under our regulations, the term medically necessary is defined as those things that adversely affect the physical health and psychological health of the mother. And that's why you have this big discrepancy between us and other states, where you have so many medically necessary abortions, is because when you throw in the word psychological, all of a sudden you've got a pretty broad definition of what is a medically necessary abortion. Technically, when the ... [Alaska] Supreme Court says that they aren't paying for elective abortions, yeah, technically that's true because we have defined just about any abortion anyone would ever want to have as being medically necessary under the terminology of the psychological health.

SENATOR KELLY then paraphrased portions of 7 AAC 47.290, which read:

> (8) "therapeutic abortion" means the termination of a pregnancy;
>
> (A) certified by a physician as medically necessary to prevent the death or disability of the woman, or to

ameliorate a condition harmful to the woman's physical or psychological health; or

SENATOR KELLY said: "The problem is, if you're going to ameliorate some condition of a person's psychological health, that terminology is way too broad, or it is my contention and (indisc. - voice faded away)."

CHAIR ROKEBERG indicated that this issue should simply be brought before the Joint Committee on Administrative Regulation Review (JARR).

SENATOR KELLY opined that narrowing the statutes would have a similar impact on the regulations.

Number 0767

KIRSTEN BEY, Member, Board of Directors, Alaska Civil Liberties Union (AkCLU), testified via teleconference. She said:

> If the main concern is that the definition of medically necessary is -- if that's what the purpose of this bill is getting at, [it] doesn't appear to me that that really gets at that at all. It just sets up a whole bunch of other terms that we don't have any definition for. What's the definition of "significantly aggravated", "seriously endanger", "highly dangerous"? And who is going to make those decisions? Instead of having one term "medically necessary", we now have three or four terms that, again, there are no definitions to that. Also, if ... a big problem in the current definition of medically necessary is to address or ameliorate the psychological health of the mother, then why does this bill so significantly curtail the medical situations, the actual, physical medical situations that an abortion can be available for to someone who cannot afford to pay for their own?
>
> To put a woman in a situation where she needs to try to decide, "Well, is this going to 'significantly aggravate' a condition I have?" or have to wait for weeks and weeks to see if a pregnancy "significantly aggravates" that, [it] just ... doesn't do anybody any good.... And ... the use of the "would" in here: in the medical arena, ... there are very few situations where a doctor can say for [a] certainty [that]

> something is going to happen. To say that that doctor has to somehow certify that a situation would happen effectively cuts out the ability of ... poor women to obtain abortions that may well be medically necessary.

REPRESENTATIVE BERKOWITZ noted that an elective procedure is defined in 7 AAC 47.290 as:

> (3) "elective procedure" means a procedure that is subject to the choice or decision of the patient or physician regarding medical services that are advantageous to the patient but not necessary to prevent the death or disability of the patient, and includes an elective abortion;

REPRESENTATIVE BERKOWITZ said, "Given the definitions that we have here for medically necessary, it would seem to me that there's substantial overlap ... between what's medically necessary and what would be considered an elective procedure." He asked Ms. Bey if she has given this matter any thought.

Number 0962

MS. BEY said that she has given this matter some thought, but noted that she has not actually seen the regulations that are being discussed. She indicated that from what has been read from the regulations thus far, there doesn't appear to be any overlap.

CHAIR ROKEBERG noted that 7 AAC 47.290 describes an elective abortion in [paragraph (7)] which reads:

> (7) "elective abortion" means a procedure, other than a therapeutic abortion, to terminate a pregnancy;

REPRESENTATIVE BERKOWITZ opined that a procedure which is defined as medically necessary according to the definition in the bill - "adverse physical condition ... that ... would seriously endanger the physical health of the woman" - would not fit into the regulatory definition of a procedure that is "necessary to prevent the death or disability of the patient". He said "endangering the physical health" seems to fall short of either "death" or "physical disability"; therefore, he reiterated, there seems to be a substantial overlap in the definitions of "elective procedure" [in regulations] and "adverse physical condition/medically necessary" [in SB 364].

MS. BEY said:

> Under that section of the bill, there's two things [that] have to happen: the ... adverse physical condition is either caused by the pregnancy or ... a condition would be significantly aggravated, and would seriously endanger the physical health.... Again, I guess it's just the whole question of the definitions: there are no definitions. So how is anyone going to really ... decide, and who's going to come in and say, "Well, what is 'seriously endanger'?" And I guess I would think "seriously endanger" would ... lead to some kind of disability, but whether it's an actual ongoing disability or something that's just temporary ... That's just one of the big objections I have to the bill, is, if the purpose of it is to ...

CHAIR ROKEBERG interjected, and opined that Representative Berkowitz is referring to the regulations rather than the bill.

MS. BEY opined, rather, that Representative Berkowitz is suggesting that portions of the bill don't fit within the regulations because "seriously endanger" doesn't go all the way to the point of causing death or disability.

Number 1187

DEATRICH SITCHLER testified via teleconference in opposition to SB 364. She said:

> I reside here in Anchorage and I am testifying for myself. I'm here to oppose this bill, and to ask you to do everything in your power to stop this from becoming law. I would like to share with you my personal reasons why this bill would be detrimental to many women with similar situations to mine. At a young age, I was diagnosed with hemophilia, a disease affecting the blood. As a result of this condition, it could be medically dangerous for me to carry a pregnancy to term because the loss of blood during delivery could be potentially fatal to me. I emphasize the word "could."
>
> There are cases where women like me have had children successfully, but at a very high risk. A high risk that they have determined they want to take. Under this bill, I probably would not qualify for Medicaid

services. My doctor is not going to say that if I take the pregnancy to term, I "would" seriously endanger my physical health. My doctor would probably say that there is, for example, a 70 percent chance that carrying this pregnancy to term "could" seriously endanger my physical health. I don't think I should be denied the right to [Medicaid] assistance because there is a 30 percent chance that my pregnancy could turn out okay.

No doctor could ever be certain of what would happen if I carried a pregnancy to term. Especially in cases like mine, where the woman has a high chance of a serious endangerment to her physical health, she should be the one who decides whether or not she is willing to take that risk. This bill could force women like me to carry their pregnancy to term and risk their own lives just because the doctor cannot say for sure that carrying this pregnancy to term "would" endanger their physical health.

MS. SITCHLER concluded:

I would also like to remind the committee members that this decision to terminate my pregnancy would be very painful for me, and I would be doing this to potentially save my own life. There are many women out there who would be forced to carry a potentially dangerous pregnancy to term and risk their own life just because they can't afford to pay for an abortion, and they don't fit into your very limited category of women whose pregnancies "would" seriously endanger their physical health. I don't think the legislature should be making these types of life-altering decisions for women just because they are low income. And for these reasons I urge you to oppose the bill as drafted. Thank you.

Number 1329

ROBIN SMITH testified via teleconference in opposition to SB 364. First, however, she read the following testimony of KATHLEEN G. TODD, M.D.; Valdez Medical Clinic:

I urge you not to pass Senate Bill 364 - limiting abortion funding. This bill excludes any consideration of fetal anomalies as a legitimate

reason for abortion, which, I assure you, are high on many women's lists of legitimate reasons for abortion. Should my patient whose fetus has multiple congenital anomalies incompatible with life caused by an unknown exposure to a teratogenic agent be required to carry to term? This bill also requires an impossibly high burden of proof to protect the mother's health. We in the medical care [field] are often faced with chances, not certainties. This bill would require a certainty before action was taken; thus precluding most actions. Abortion and pregnancy must remain a decision made by individuals who can assess risk and weigh these risks based on their own value systems.

In thinking about abortion funding, we need to keep in mind where fairness lies. Those who argue against spending government money on abortions, as something they don't believe in, forget that other people also have deeply held beliefs. It's against my convictions to knowingly carry to term a grossly deformed baby or to try to carry septuplets or to endanger my life for the sake of a fetus. I wouldn't do it, and I wish that ... state money wasn't spent on these kind of pregnancies. However, I don't think the state should cut off all funding to a woman who doesn't have an abortion in these circumstances. She might believe differently than I do. The government needs to stay neutral, not allowing anyone to impose abortion on women - including the poor - but likewise, not allowing anyone to impose pregnancy on them.

Number 1449

MS. SMITH, on behalf of herself, said:

I also just want to say that I ... oppose SB 364. This bill cuts deep into the doctor/patient relationship. I believe it sets precedent. I don't think we really want the [legislature] make health care decisions for a person just because they're low income. And I'm really kind of sorry that Representative Ogan isn't here, because I wonder if there hasn't been a time in his past where he hasn't had insurance and would have been considered low income. And would he actually want the legislature determining the type of health care he can get, or

whether or not a pacemaker was really medically necessary?

Feedback that I get from the doctors in the field are that they're being cautious; doctors are using Medicaid funds only when it is (indisc.) necessary to (indisc.) court ruling. They fear financial consequences - loss of payment or a lawsuit - if the abortion is not medically necessary. [So] they've been very leery to perform ... any abortion that isn't medically necessary. Thank you; I hope you stop this bill now.

CHAIR ROKEBERG noted that the Alaska Supreme Court has made a ruling in which it uses the term "medically necessary" over 30 times. He stated:

As the sponsor of the "Alaska Patients' Bill of Rights" bill, I struggled for three years working with the insurance industry and with the Alaska Medical Association, trying to define the "medical necessity." I failed. I worked on it for three years. I want everybody to be very aware of this right now. So I'm a super skeptic ... [with regard to] a good deal of this type of debate.

Number 1542

PAULINE UTTER testified via teleconference in opposition to SB 364. First, however, she read the following testimony of JAN WHITEFIELD, M.D.; Alaska Women's Health Services, Inc.:

Senate Bill 364 is dangerous to the women of Alaska. Consider a woman with Class D diabetes who becomes pregnant. She may develop blindness during pregnancy secondary to retinal detachment, or may develop renal failure. She has an increased incidence of pregnancy-induced hypertension in pregnancy that may cause her to have a seizure and subsequent stroke. While I can tell a woman of these risks, I am not able to predict the future and tell her whether she will or will not get any or all of these problems. I am simply aware of the increased risk compared to other women and can counsel her to these risks. As a physician, I cannot state with 100 percent assuredness that a woman will or will not develop a particular problem. The same is true [for] many other problems in pregnancy such as

hypertension, seizure disorders, Lupus, and many other disorders too numerous to list.

Similarly, if I put a patient on a particular medicine in pregnancy to treat a disorder such as Lupus, hypertension, or depression, I cannot tell the patient with 100 percent surety that a particular drug will or will not affect her baby. Just read any package insert of most drugs, and the manufacturers will discuss the risks of a drug in pregnancy. It becomes very clear that there are no guarantees in medicine. Prednisone is commonly used to treat Lupus and asthma in pregnancy. The Physicians' Desk Reference says: "Since adequate human reproduction studies have not been done with [corticosteroids] (prednisone), the use of these drugs in pregnancy, nursing mothers, or women of childbearing potential requires that the possible benefits of the drug be weighed against the potential hazards to the mother and embryo or fetus. Infants born of mothers who have received substantial doses corticosteroids during pregnancy should be carefully observed for signs of hypoadrenalism".

Number 1637

The testimony of Dr. Whitefield as read by Ms. Utter continued:

I may see an unmarried woman who works to support herself and her three children, and she may relate that she is severely distressed over a current pregnancy. She may request an abortion, or wonder about being placed on an antidepressant. All antidepressants have possible risks to the fetus. Consider Prozac, a commonly used antidepressant. In the book Drugs in Pregnancy and Lactation, a standard reference text in this field by Gerald Briggs, Ph.D. in Pharmacy, the following quote can be read: "Because at least one animal study has shown that fluoxetine (Prozac) can produce changes, perhaps permanent, in the fetal brain, the maternal benefits must be carefully weighed against the potential embryo and fetal risks before exposing a pregnancy to this drug."

Should I or should I not give this drug to this patient? Will it affect her fetus? Is this drug dangerous to the fetus? Will her life be negatively

affected or endangered if I do not give her the drug? You may be able to answer those questions, but I can't. I am a physician, not a soothsayer. These are only two of an infinite number of examples that can be presented with equally ambivalent answers. As physicians we can anticipate possible outcomes, but cannot predict with 100 percent certainty any specific outcome. This law, if enacted, will surely eliminate the payment of many abortions by the State of Alaska. However, the pregnant women, with their difficult problems and uncertain outcomes, will remain and will suffer the consequences. They are the ones who will lose their sight, or have the stroke, or have their kidneys fail. While it may gain a politician some points with certain constituents, the women of Alaska will suffer. Please consider the health of the women and do not allow this bill to pass through your committee [or] the general body of the Senate and House.

Number 1734

MS. UTTER, on behalf of herself, said, "Of all [the] hearings that I've been to on this bill ..., we've yet to see any physicians testify that they were in favor of this bill." She opined that it is critical for legislators to consider the bill's lack of physicians' support.

Number 1759

LEILA WISE testified via teleconference in opposition to SB 364. She opined that SB 364 is unconstitutional, is bad public policy, and would certainly result in [women] getting bad health care or inadequate health care. She said that she can understand that some legislators do not wish to see medically necessary abortions for poor women paid for with state funds; nonetheless, the courts have said that state funds must be used in the context of medically necessary abortions. She opined that the efforts to circumvent the courts on this issue does [all Alaskans] a disservice, and that enacting this legislation would be a bad idea. She urged the committee to not pass SB 364.

CHAIR ROKEBERG, referring to the constitutionality of SB 364, offered that the legislation would merely define what the Alaska Supreme Court said with regard to this issue.

Number 1853

JOHN MIDDAUGH, M.D., Chief, Epidemiology Section, Division of Public Health, Department of Health & Social Services (DHSS), testified in opposition to SB 364. He explained that he is board certified in internal medicine and preventive medicine, and has been practicing medicine in Alaska since 1975. He said:

> My comments today are meant to convey concerns, from a physician's point of view, related to the practice of medicine and to the difficulty of applying the legal language being proposed in this legislation within the context of the physician-patient relationship. You've heard already in some of the testimony very similar things that I just quickly and briefly will reiterate. In the absence of a clear understanding of the meaning of the language in the proposed legislation and its interpretation, physicians will have great problems in signing the certifications required by the legislation, not because of a concern over the medical need of the procedure, but due to uncertainty over the vagueness of the language.
>
> All of the terms that are restricting or proposed to be restricting the definition of "medically necessary" bring their own problems: "serious adverse physical condition", "significantly aggravated", "seriously endanger the physical health" - those, every day in the practice of medicine, are things weighed between a physician with clinical training and clinical judgment in cooperation with the patient, in their own circumstances, discussing options and probabilities to arrive at [a] course of action ... that's optimal for that patient in that circumstance.
>
> The terms as proposed in the language are not clear and ultimately would have to be interpreted later in order to enforce the statute. But who would make the decision, and based upon what? In the absence of knowledge of the legally and ethically confidential and intimate disclosures between the patient and physician, how is that third party, without knowledge of the facts, going to be able to determine if the circumstances did "seriously endanger the physical health" or if "serious adverse physical conditions" are ... "[significantly] aggravated".

Number 1959

DR. MIDDAUGH continued:

> You've heard about the concerns over the use of the term "would", as opposed to "might" or "could", and I want to reiterate those. I think you know, ... in your own medical care, that physicians don't and are not able to use terms with 100 percent certainty. And I'd also like to call [to] your attention that the bill excludes from coverage the tragic circumstances where there's a pregnancy but where, with modern medical knowledge and diagnostics, it can be determined that that fetus can't be viable at the end of pregnancy, yet this woman would not be able to get a procedure covered by these funds.
>
> I think that there's no evidence of an "epidemic" of elective abortions. We know that the policies of the state are not to pay for elective procedures, and we also know that the rates of these procedures are not an epidemic in Alaska, and, in fact, the rates in Alaska are lower than the national average. There's no science- or medical-based evidence or justification for the proposed language. The legislation embodies a rejection of the basic principles of the practice of medicine and the powerful systems that assure accountability for the standards of that medical practice. As you value the basic principles of medical practice as an individual, a legislator, and an eventual patient, as a physician, I urge you not to support this legislation. Thank you.

CHAIR ROKEBERG asked Dr. Middaugh for his interpretation of the language in regulations that says, "to ameliorate a condition harmful to the woman's physical or psychological health".

DR. MIDDAUGH said:

> It would be consistent with the standards of medicine to consider the courses of impact on a woman's health, either physically or psychologically. For example, take the circumstances of a woman, as you heard, with diabetes who has a severe problem with diabetes and controlling the blood sugar and blood pressure, faced with potential ... threatening blindness; hypertension

> threatening stroke; exacerbation of renal disease, threatening loss of kidney functions - and having to weigh her own health against the potential of having to have a termination of a pregnancy. What's the psychological damage to that woman as she has to weigh those values? It's not unusual to have that precipitate a severe depression and, depending on how severe, could even result in a woman becoming suicidal.

Number 2116

> I think that's exactly why the weighing of these factors isn't a formula. It's not able to be done just by a simple matter applicable across the board to every patient. It's one of the most difficult choices faced by a woman and by a physician in counseling a woman about those factors. And health is more than just physical; the link between psychological and physical health is a quite powerful one, as I know you know.

CHAIR ROKEBERG remarked that the word "ameliorate" seems to be "an awfully broad term," and he would interpret it as having a good deal of "liberality." He asked Dr. Middaugh if he agreed.

DR. MIDDAUGH said:

> I would say that it's very consistent with your opening comments. If you and others, with three years of concentrated effort to attempt to define "medical necessity", were unable to do so, I would argue that that's exactly why these terms need to have a broad ability, so that a physician and patient have the ability to determine and weigh options in order to take into account the almost infinite number of severely and often unpredictable medical and psychological complications [that] can result from our human condition.

CHAIR ROKEBERG asked Dr. Middaugh to explain what he thinks is unclear about the language in proposed (b)(1)(A) and (B).

DR. MIDDAUGH said that the language is unclear because the standard being used is "would".

Number 2234

CHAIR ROKEBERG disagreed, adding that there "is a disjunctive 'or' there."

DR. MIDDAUGH remarked that as a physician, he would be very pleased with the bill and would support it if, on line 12 of page 1, a period were added after "medically necessary" and the remaining language were deleted. He opined that "this list of qualifiers" creates additional problems of interpretation and "drops out" other instances when there clearly would be medically necessary procedures but they've been excluded due to the "lack of consistency" in the phrases used after "medically necessary".

CHAIR ROKEBERG opined that the language in SB 364 is clearer than the language in the regulations.

DR. MIDDAUGH, in response to questions, said that currently, doctors make the determination regarding a patient's psychological health, and that the medical degree allows them to make such determinations without assistance from outside sources.

CHAIR ROKEBERG asked Dr. Middaugh whether he had any suggestions regarding language that could be inserted which would address the issues of nonviable fetuses and fetal anomalies.

DR. MIDDAUGH said he did not have any changes to suggest that would address those issues. He reiterated his suggestion to simply delete all text after "medically necessary". In response to the assertion that the legislature would then "be stuck with" the regulations, he opined that the language in the regulations is very appropriate and that defaulting to it would be adopting "a high standard of practice of medicine."

TAPE 02-61, SIDE B
Number 2340

LISA VILLANO testified via teleconference in opposition to SB 364. She opined that SB 364 will be detrimental to the women and children of Alaska. She remarked that this issue should be kept between a woman and her doctor, and she urged the committee to "keep the bureaucracy out of it." She relayed that according to an e-mail she received, "these bills only cover abortions if the woman's health is at risk; fetal anomalies are not considered." She added that it would be horribly cruel and barbaric to force a woman to carry to term a pregnancy in which

the fetus is so deformed or ill that it cannot survive outside the womb. She requested that the committee not pass SB 364.

Number 2275

KRISTEN BOMENGEN, Assistant Attorney General, Human Services Section, Civil Division (Juneau), Department of Law (DOL), noted that as a routine part of her duties, she advises the DHSS. She said that she has come before the committee in order to address the legal problems that are posed by the definition as it appears in SB 364, and that she would do so by turning the committee's attention to [State Dept. of Health & Social Services v. Planned Parenthood of Alaska, et al. (07/27/2001) sp-5443]. She said that the court described this case as one that concerned the state's denial of public assistance to Medicaid-eligible women whose health is in danger. She read from the paragraph that stated:

> The range of women whose access to medical care is restricted by the regulation is broad. According to medical evidence provided to the superior court, some women -- particularly those who suffer from pre-existing health problems -- face significant risks if they cannot obtain abortions. Women with diabetes risk kidney failure, blindness, and preeclampsia or eclampsia -- conditions characterized by simultaneous convulsions and comas -- when their disease is complicated by pregnancy. Women with renal disease may lose a kidney and face a lifetime of dialysis if they cannot obtain an abortion. And pregnancy in women with sickle cell anemia can accelerate the disease, leading to pneumonia, kidney infections, congestive heart failure, and pulmonary conditions such as embolus. Poor women who suffer from conditions such as epilepsy or bipolar disorder face a particularly brutal dilemma as a result of DHSS's regulation -- medication needed by the women to control their own seizures or other symptoms can be highly dangerous to a developing fetus. Without funding for medically necessary abortions, pregnant women with these conditions must choose either to seriously endanger their own health by forgoing medication, or to ensure their own safety but endanger the developing fetus by continuing medication. Finally, without state funding, Medicaid-eligible women may reach an advanced stage of pregnancy before they can gather enough money for an abortion;

resulting late-term abortions pose far greater health risks than earlier procedures.

Number 2207

MS. BOMENGEN said that the conclusion of the [Alaska Supreme Court] was that once the state undertakes to fund medically necessary services for poor Alaskans, it may not selectively exclude from that program women who medically require abortions. [Senate Bill 364] endeavors to define the term "medically necessary", but in doing so, she remarked, it essentially sets up two groups of women: Those who are very much in need of a medically necessary abortion, and then other women who may also, for medically indicated reasons, be facing the necessity of addressing their medical condition with an abortion as one of their options.

MS. BOMENGEN said that the decision of the [Alaska Supreme Court] in the aforementioned case was based on an analysis of the equal protection clause, and it mandated equal protection of all those similarly situated, and it defined the group in the case as "all women for whom abortion is medically necessary. She reiterated that the definition in SB 364 creates a division based on the enumerated reasons in [paragraphs (1)(A)(B) and (2)(A)(B) of the bill]. Therefore, "you'll have a group of women for whom [an abortion is] medically necessary who fall outside of those enumerated reasons, and ... that really makes this definition vulnerable to constitutional challenge," she warned.

MS. BOMENGEN, referring to the term "would", went on to say:

> We've heard testimony that medical practice is not really done with the kind of certainty that predicts that a set of medical conditions will lead to a certain result. If we look at the middle of the paragraph, the case itself says, "Women with renal disease may lose a kidney and face a lifetime of dialysis if they cannot obtain an abortion". But it's not a certainty; ... the likelihood is a variation ... [that] runs along a line, and so ... we have the "may". Also, "pregnancy in women with sickle cell anemia can accelerate the disease", but it doesn't, in all cases, accelerate the disease.
>
> How will that determination be made? That is one of those things [for which] ... a doctor needs to be able

> to look at the condition of the patient. To the extent that the term "would" appears in ... [SB 364's] definition, I suspect that it will create confusion for doctors, and [that] applying it will be viewed as overly restrictive for medical practitioners when they try to apply it - the term's not based on sound medical-practice terminology - and that the definition will likely be found to be constitutionally infirm on those premises.

Number 2073

MS. BOMENGEN said:

> By using "would" rather than "could", it does raise the level of certainty that you're expecting of the medical practitioner, and it places that practitioner in a dilemma if they are trying to make certain that they are falling within the law, which conscientious practitioners are doing.

MS. BOMENGEN, in response to a question, pointed out that notwithstanding the use of the disjunctive "or", "would" gets read into all of the [qualifiers] listed in the bill.

CHAIR ROKEBERG agreed that "would" is a stronger word than "could", and noted that according to Black's Law Dictionary, "would" will be interpreted more as "should". He also mentioned that the sentences in SB 364 contain both conjunctive and disjunctive elements.

MS. BOMENGEN, in conclusion, reiterated that use of the word "would" will create two groups of women, and, in so doing, will subject the legislation to equal protection challenges.

CHAIR ROKEBERG referred to language on [page 1] lines 4 and 5 of SB 364, which read, "(a) Except as otherwise required by federal law". He asked Ms. Bomengen whether this language fully covers the provisions of the Hyde Amendment, according to her understanding.

Number 1830

MS. BOMENGEN said, "I assumed that was what it was intended to do, and when I read it, I don't immediately identify a problem with it." In response to another question, she concurred that the provisions of Hyde Amendment are included under the

aforementioned language. In response to a question of whether she would [be more comfortable] if "could" were used in place of "would", she said:

> As I analyze the case - again, I'm looking at the language in the case - and the case talks about "may" and "can" as the words indicating, when a woman has a particular medical condition, what the outcome might be. And so simply looking at the words "would" and "could", "could" works more appropriately with ... [that] type of medical determination - though I guess I would defer to a doctor, as well, in terms of how that language would be applied - but from the testimony we've heard, a doctor would be working more comfortably in that kind of predictability when dealing with a patient.

CHAIR ROKEBERG surmised, then, that using "could" instead of "would" will provide physicians with more discretion and flexibility.

MS. BOMENGEN agreed that "would" and "could" are gradations of different consideration. In response to a question of how to improve SB 364, she, too, suggested that placing a period after "medically necessary" on line 12 [and deleting the following text] would be the better solution. She also suggested that another way to address [the sponsor's concerns] would be to focus attention on the regulatory definitions, which have not been altered since 1997, and ensure that they reflect the findings of the recent Alaska Supreme Court case, State Dept. of Health & Social Services v. Planned Parenthood of Alaska, et al. [(07/27/2001) sp-5443]. She suggested that doctors would have more of an opportunity to weigh in on the issue if it were addressed through the process of rewriting the regulations and their accompanying definitions.

Number 1601

COLLEEN M. MURPHY, M.D., Obstetrician-Gynecologist, testified via teleconference in opposition to SB 364. She said:

> The language of [SB 364] is really not comprehensible to medical practitioners. Currently, some of our highest-risk patients that have a risk of dying from a pregnancy, some of the highest-risk conditions we have are things like Marfan's syndrome, with enlarged aortic roots, that with the rigors of labor can

dissect and cause ... [women] to die up to 50 percent of the time. Likewise, pulmonary hypertension is a condition that can cause cardiovascular death in pregnant women that can happen up to 50 percent of the time. And, again, when I look at your definitions of "[medically] necessary", how high does a woman have to risk death in order to meet these standards? Fifty percent might not be high enough. Ten percent? Twelve percent? What would you want for your wife, your mother, your daughter?

So "medically necessary" can be broadly interpreted. And frankly, even pregnancy itself is twelve times more dangerous than a safe termination of pregnancy done in a legal setting; we know that if a woman carries a pregnancy to term, she (indisc.) twelve times a higher likelihood of dying, for what was presumed to be normal pregnancy.... I personally have a very hard time interpreting "medically necessary", because what ... the current risk [is] to the woman that makes it acceptable to the Medicaid program is not clear.

I do want to also advise your group that currently the United States now ranks number 12 in the world for the incidence of maternal mortality. Approximately 1.2 women die per 100,000 in our country, and we're far behind the Scandinavians, the Japanese, and other Western European countries. And by basically saying that we would limit terminations of pregnancy to very high-risk pregnancies, you're basically asking for higher risk of maternal mortality, both for elective terminations of pregnancy and for ones that are higher risk....

Number 1464

DR. MURPHY, referring to the issue of psychological [health], said:

That is (indisc.) difficult question for doctors to discern, and I just want to invoke a very high-profile case that we recently saw widely discussed in the media. And that was Andrea Yates; she is [a] woman who was pregnant multiple times, with a known depressive disorder, and then went on to basically murder her children during a psychotic episode, and

now will be spending life in prison. How could a doctor have predicted that her depressive disorder would've resulted in such an outcome?

How do I predict the nature of a woman's depression in the first trimester of pregnancy and how it may worsen or improve, or even result in psychosis and serious depression postpartum? I am not a genie; I am not a magician. But when a woman tells me that she's depressed and she can't care for this pregnancy or the eventual child, I greatly fear for the outcome. And so, again, I find that as a practicing doctor, ... the terminology you have in your bill is very, very difficult to interpret; it's very subjective in the decision making that should be kept between the doctor and [his/her] patient. Thank you.

DR. MURPHY, in response to a question, replied:

We know that women do get postpartum blues 80 percent of the time; 15 percent of women will get postpartum depression; and one in a thousand will get postpartum psychosis. And when a woman basically tells me that she's already depressed in early pregnancy, I fear greatly that she'll fall [into] the more significant categories, not only during her pregnancy but post-delivery.

CHAIR ROKEBERG asked whether she would normally prescribe medication for "that type of psychological manifestations."

DR. MURPHY explained that most medications currently used for depression are what are called "category C drugs," for which [physicians] don't have experience pertaining to human [reproductive] consequences. "We have experience in rats, we have experience in mice, but we can't predict the outcomes necessarily in humans," she added. She remarked that experience with the way those drugs affect human reproductive systems is now being accumulated by virtue of using them on humans. Notwithstanding the accumulation of this incoming data, however, category C drugs are generally to be avoided during pregnancy, she noted. She said: "And [I] certainly would feel very uncomfortable ... prescribing category C drugs with the frequency that they may [be] required, [while] denying a woman termination of pregnancy when she's requesting it for psychological reasons."

Number 1289

DR. MURPHY, in response to a question, said:

> There's three categories of drugs, actually four categories of drugs, that pharmacies classify. Category A is known to [be] safe in humans throughout all three trimesters of pregnancy. Category B basically is another classification that we have some human experience [in], but we should avoid it in the first trimester. And category C means we only have animal data. And then category D is a teratogen. And like right here under your [paragraph] (2)(A), "the medication required to treat the illness would be highly dangerous to the fetus"; well there's about 8 to 10 known teratogens - things that are known to cause birth defects.
>
> [For example] lithium; lithium, when taken in the first trimester, can cause an anomaly of the heart called Ebstein's anomaly, [which] occurs [in] one in 10,000 pregnancies - it's called a teratogen. Accutane, which is taken by mouth for acne, if taken in the first trimester can cause cranial-facial deformities - a small head - up to 40 percent of the time. Is that high enough for you? Or do I make the woman carry to term to find out she has a baby with a profoundly abnormal central nervous system.
>
> A woman who takes [the seizure medication] Dilantin in the first trimester of pregnancy has [a] 10 percent chance of having a baby with an abnormal brain and abnormal facial features [and] small fingers. Is that high enough for you? Methotrexate, if inadvertently taken in the first trimester of pregnancy, will create limb deformities. Shall we wait and see, when the baby turns out? [Diethylstilbestrol] DES, if taken in the first trimester, can cause abnormal uteri - cancers - in the women who later go on in their reproductive age. Is that high enough for you? Alcohol, the most common teratogen: even the worst alcoholic will have 40 percent incidence of fetal alcohol syndrome [FAS]. Is that high enough for you? She's been drinking every day [for] last two months [and] she doesn't want to be pregnant. Is that high enough for you?

DR. MURPHY concluded by saying: "That's what I deal with. It's not 100 percent. It's [an] ... objective assessment and plan - the individualized care. You watch a woman cry; you listen to them tell you about their lives and how hard it is."

Number 1162

REPRESENTATIVE COGHILL remarked that after people are born, they are not killed just because they suffer from deformities or because their parents have severe psychological problems, and that [SB 364] raises a philosophical issue. He opined that Dr. Murphy was being facetious in asking the question, "Is that high enough for you?"

DR. MURPHY countered that she is merely offering testimony as a doctor, an obstetrician-gynecologist, and a scientist. She said:

> Well here I am testifying and telling you that when we do an informed consent, we're actually scientists; we don't actually bring in, hopefully, our own subjective life-views. We basically give patients percentages of outcomes because nothing is 100 percent. We can tell you that if you do "this," 25 percent of the time "this" may happen; if you do "that," another 30 percent. [And then we'd ask], "What do want to have done?" Nothing ever occurs 100 percent of the time. And so, frankly, we try to take the data that's accumulated in the medical literature and give women their best advice about the outcome of their pregnancy.
>
> But we don't have the science that your current bill would suggest, to basically have the decision making to proceed with this, because in fact nothing is 100 percent. And, again, you're asking me as a scientist, and a doctor, a woman, an [and] OB/GYN. Currently the definition of pregnancy is a successfully implanted fertilized egg, and that's the definition that is ascribed to by the World Health Organization, the National Institute of Health, and the [American College of Obstetricians and Gynecologists]. And, again, as you well know, ... "unborn child" is not a scientific terminology; it's called an embryo to eight weeks, and a fetus thereafter, and then a "live born" after delivery.

REPRESENTATIVE COGHILL surmised, then, that Dr. Murphy is saying that the term "would" does not allow doctors enough discretion.

Number 0952

DR. MURPHY replied that in spite all the time and effort that has gone into this legislation, it can still be interpreted "any way you want. She elaborated:

> And, frankly, it will be interpreted in the privacy of the office setting; with individual health care, one woman thinks that the psychological illness ... is serious enough to impair her health or endanger her health. Because one woman might find a 5 percent risk of death too great, another woman might -- like right now I have a diabetic woman who's basically bled into her eyes and can't drive right now, who's 23 weeks pregnant, with renal failure.... She's continuing her pregnancy even though she's probably going to lose her kidneys and her eyesight in the next two years. But she's willing to take that risk to bear a child. There are other women that don't want to take that risk. But it's an individual choice.

DR. MURPHY, in response to a question, offered that according to the available information, only 20 to 30 percent of what most medical doctors do is data-driven, and that much of the rest is based on anecdotal evidence and local practice. She indicated agreement that medicine is both an art and a science: "It is an art of medicine [in] that we do the best we can with the available data, and we continue to monitor the results and hopefully collect more information about outcomes to guide us in the future."

CHAIR ROKEBERG turned to the issues of fetal abnormalities and nonviable fetuses. He asked Dr. Murphy to comment on those issues. He also asked whether carrying a nonviable fetus to term is a common situation, and what percentage of pregnancies are "naturally lost or aborted."

DR. MURPHY said:

> Well, first off, we basically classify a miscarriage as a pregnancy lost prior to 20-weeks' gestational age. After 20-weeks' gestational age, it's called an intrauterine fetal demise, and it just so happens I was on the web today doing "question of the day" and

> that was [one] of the topics. Interestingly enough, you call it perinatal mortality; perinatal mortality includes the death in utero - intrauterine fetal death - plus neonatal death in the first month of life. Basically at this time, ... six per thousand pregnancies are an intrauterine fetal demise, and about four per thousand pregnancies are neonatal death. So, actually, intrauterine fetal demises occur more frequently than postnatal death within the first month of life. So they occur six per thousand women, two-thirds of which occur after 35 weeks' gestation.... About one-half of those, we don't know why they occur, and the other half are related to birth defects, maternal disease, [and] other things.

Number 0742

CHAIR ROKEBERG said he thought the rate of spontaneous termination of pregnancy was much higher.

DR. MURPHY said:

> Well miscarriages - those are prior to 20 weeks - they are much higher. If you look at some of the reproductive data out there, up to probably 60 to 70 percent of fertilized eggs never implant, and then once ... [the remaining percentage] implant, [they] produce pregnancy hormones; about 15 to 20 percent of all pregnancies will then miscarry. But that's, again, prior to 20 weeks - that's a miscarriage - that's not an intrauterine fetal demise.

CHAIR ROKEBERG said he has a concern regarding how the language in SB 364 would work under certain circumstances such as when there is a nonviable fetus. He asked, "So those things happen with some frequency, like even particularly 'FAS children'?"

DR. MURPHY said yes, adding that there are a lot of causes of pregnancy loss. She noted that if a heartbeat is not detected prior to 20 weeks' gestational age, if left alone, women will successfully miscarry spontaneously 80 percent of the time - the women don't necessarily have to go to dilatation and curettage. After 20 weeks' pregnancy, she explained, with the majority of women [in that situation], the tissue will start to degenerate, which sets up a chemical reaction that results in labor. However, after retaining a dead fetus for three weeks, Dr. Murphy pointed out, some of the breakdown products can result in

something called disseminated intravascular coagulation in which the woman's blood will start to thin, causing her to spontaneously bleed, and could result in her bleeding to death when she delivers the fetus and placenta. She elaborated:

> So after carrying an intrauterine fetal demise [longer] than three weeks, we generally will monitor the woman's blood to make sure she's not developing that disseminated intravascular coagulation, which would be jeopardizing to her, rather than continuing expectant management, waiting for the spontaneous onset of labor. So basically it's medically indicated to consider delivering a dead fetus for the sake of the mother if she hasn't passed the tissue and fetus within about a month, and psychologically they ofttimes want to, also, move on.

CHAIR ROKEBERG surmised, then, that the interpretation of any forthcoming statutory language will occur "by a physician in the privacy of [his/her] office with [his/her] patient."

Number 0589

CHIP WAGONER, Alaska Catholic Conference, testified in support of SB 364. He remarked that at the federal level, federal funds are not used to pay for abortion unless the life of the mother is at risk, or the pregnancy is the result of rape or incest. He said, "The United States Supreme Court has upheld that law, stating that the federal government - under equal protection of the U.S. Constitution - need not fund any other kinds of abortions." He added, "They've also said ... that states, under the U.S. Constitution, are not required to fund abortions." Referring to 7 AAC 43, he said that the Medicaid regulations that the court dealt with are what he thinks of as the "mini Hyde Amendment," and surmised, therefore, that according to those regulations, the state, too, would only have to pay for abortions in which the life of the mother is at risk, or the pregnancy is the result of rape or incest.

MR. WAGONER observed that it was these regulations which the Alaska Supreme Court recently determined were in violation of the equal protection provision of the Alaska State Constitution. He opined that in making that determination, the Alaska Supreme Court "basically threw out the ... Medicaid regulation relating to abortions." He referred to comments made by Ms. Hall, and then offered his interpretation of how doctors get paid for abortions under the Medicaid program. He then offered his

opinion that when doctors [code] an abortion as uncomplicated, they are referring to an elective abortion. Mr. Wagoner repeated the 1997 statistics detailed by Ms. Hall in her opening remarks, and suggested that the DHSS has more recent statistics.

MR. WAGONER acknowledged that Ms. Bomengen made some good points, and agreed that SB 364 would create two classes of women. He opined that the difference between those two classes of women is that one class would be those whose abortions are medically necessary, and the other would be those whose abortions are elective. He said that according to his knowledge, abortion is the only medical procedure paid for by the Medicaid program that can be performed for either medically necessary reasons or as an elective procedure. Because of this, he opined, there has to be line drawn somewhere in order to differentiate between medically necessary abortions and elective abortions.

MR. WAGONER offered the aforementioned 1997 statistics as "proof positive that that bright line is not there." "And there needs to be that bright line there," he added, "because Medicaid dollars to help poor people should be paid for helping poor people with medical problems, not for people who just want an abortion." He remarked that although it may be difficult to draw that line, SB 364 provides that the department shall promulgate regulations to implement the bill. He again opined that an abortion coded as an "uncomplicated legal abortion unspecified" is merely an elective abortion. He also opined that SB 364 will not in any way interfere with the doctor-patient relationship, but rather will simply ensure that Medicaid funds do not pay for elective abortions. He remarked that the [Alaska Supreme Court] was quite clear when it said that if the state is going to provide medical services to poor people, it had to provide medically necessary abortions. He pointed out, however, that the court did not say that the state had to provide "abortion on demand."

TAPE 02-62, SIDE A
Number 0001

MR. WAGONER suggested that the sponsor probably took some of the wording in SB 364 directly from the recent Alaska Supreme Court case. Referring to the term "would be significantly aggravated", he opined that such terminology is not as restrictive as [opponents of SB 364] have suggested. In response to a question, he surmised that the term

"significantly" is used because of the 1997 statistical information.

CHAIR ROKEBERG offered that to simply say "adverse physical condition ... would be aggravated by continuation of the pregnancy" is sufficient; therefore, there is no need to include the [qualifier] "significantly". "That just raises the standards even higher," he noted.

MR. WAGONER agreed.

CHAIR ROKEBERG remarked that having "adverse physical condition" as a predicate eliminates the need to qualify "aggravated by continuation of the pregnancy" with the term "significantly", particularly since that language is conjunctively linked with [subparagraph (B)].

MR. WAGONER argued that some could say that merely being pregnant for nine months is aggravating; thus inclusion of the term "significantly" would clarify further that the abortion was truly "medically necessary."

CHAIR ROKEBERG asked, "So you're hanging the whole definition of 'medically necessary' on the word 'significantly'?"

MR. WAGONER clarified that he did not mean to imply such. He suggested that when promulgating regulations, the department could provide further interpretation on a case-by-case basis. He opined that if SB 364 passes, it "will clearly show what the intent of the legislature is."

CHAIR ROKEBERG pointed out that the terms "significantly", "seriously", and "highly" are adverbs, words which modify - or qualify - other words. He remarked that after investigating the term "medical necessity", he felt that there is a need for physicians to have flexibility. He suggested that using the aforementioned adverbs will "raise the bar."

MR. WAGONER agreed.

Number 0332

CHAIR ROKEBERG surmised, then, that at issue is not whether an abortion is "medically necessary"; rather, it appears that in using the aforementioned adverbs, the goal of SB 364 is simply to create a higher level of "medically necessary". "You're shifting the standard ... by using these adverbs; you're'

raising the gradient, but that's ... a sub-definition within what you're trying to do here," he added.

MR. WAGONER argued that using such terms is not new, for example, the definition of "emergency hospital services" says, serious impairment of the health of the individual".

CHAIR ROKEBERG pointed out, however, that that definition uses the word "serious", not "seriously". He remarked that in terms of a legal construct, he has concerns regarding [the use of the aforementioned adverbs].

MR. WAGONER said:

> A court, when they first look at this, statutes are presumed to be constitutional. And I think what they would have to do ... [would be] to look at how this was being implemented to see if ... [Ms. Bomengen's] view that two different classes of really, truly medically necessary abortions were being created, where one was being paid for and one wasn't.

CHAIR ROKEBERG remarked that regardless of where one stands on the issue of abortion, when laws are drafted, they should be drafted in such a way that they hold up in court.

MR. WAGONER agreed.

CHAIR ROKEBERG reiterated that this issue would more appropriately be an issue for the JARR to consider, since "a lot if it has to do with regulations."

Number 0509

SIDNEY HEIDERSDORF, Alaskans For Life, Inc., testified in support of SB 364. He said:

> First of all, we support SB 364; we support any effort with the goal of trying to restrict state involvement with the funding of abortion. It would be, certainly, not ideal in our minds, but we believe that this bill does contribute or accomplish at least a portion of this goal, which is to get the state out of the abortion business. My comments here are going to be more of a general nature, and - as opposed to specific portions of the bill - we've been talking all afternoon ... kind of in sterilized terms, quibbling over the meaning of words, which I'm not saying is not

important, but ... we're aloof from the real issue. And we are in fact talking about life and death issues, and so when we use words like "procedure" and "termination of pregnancy", I think we're kind of getting away from the real ... issue at stake for many ... of us....

While we're doing this, babies are being destroyed, and I couldn't help but think of the statement ...: "Boys throw stones at frogs in jest, but the frogs die in earnest." So we're sitting here today talking in this very sterilized fashion, and we're talking about a very, very serious issue. I would like to point out that ... the regulations that people were referring to ... were objected to by the same people saying the same thing when those regulations were adopted, [at] hearings for those regulations. So, I'm sure you're well aware that nothing in this area is going to satisfy the crowd that supports abortion. And that's why you get the ... pro-abortion doctors calling; the doctors that don't do abortions, this is not an issue with them - they just practice good medicine. So that's why they're not coming forward, because this is not an issue that they deal with.

Number 0699

MR. HEIDERSDORF continued:

I would like to say just a few words about this elective abortion issue. About 25 years ago, in [the] Hammond Administration, there was an issue which arose where the state contract with "Blue Cross" forbad the spending of money for elective procedures. And the state Department of Administration ordered Blue Cross to stop paying for those procedures.... You can imagine what a stir that caused, and it eventually, of course, went to the governor's office, and at that time Avrum Gross was the Attorney General. And he wrote an opinion which said Blue Cross had to pay because elective abortions had to be done by doctors; therefore, they were medically necessary. And the reaction from anyone who looks at what the word "elective" means, versus "medically necessary", we should have all just risen up and laughed in derision about making such a statement.

> But that statement stood. And the state had to go back and tell Blue Cross, "You still have to pay for these," as if we could not decide what an elective abortion was.... When the issue is abortion, I think we all know the rules change, and we've seen that with our courts and all kinds of things. And of course when I thought about that, I was thinking about the fact that there have been claims made in testimony that all of the abortions paid for by Medicaid funds this past year were medically necessary, rather than elective. But I think this is a classical case of doublespeak, just like Avrum Gross's memo. They're not all medically necessary. There are many of them - a very high percentage - [that] are elective. And, of course, the problem is the wording in the regulations, which is a terrific problem to try to resolve ...; when you start using words like "health" and "psychological indications", you open the door, and we've got abortion on demand.

Number 0862

MR. HEIDERSDORF referred to the [1997] statistics, and remarked that in 1998, the legislature made great efforts to restrict abortion funding and was successful for short periods of time "until the courts got their hands on the issue." He purported that although the state paid for [over] 1,000 abortions in 1997, in contrast, the state only paid for 15 in 1998. He opined that this means that at least 300 to 400 babies were saved, adding that this is assuming that some of the women "went elsewhere" when they were told that Medicaid would not pay for their abortions.

MR. HEIDERSDORF said:

> There are many of us out there who are very thankful for [what] the legislature has done over the years in attempting to get a handle on this payment for abortions. It is an issue that rankles very deep for many of us, and it's the state's primary responsibility to protect life.

MR. HEIDERSDORF opined that when the state is involved in paying for abortions, the state clearly is not living up to that responsibility. He remarked that in paying for abortions, the state is promoting abortions. He asked the committee to do everything possible to minimize state involvement in the

"abortion business," adding that he is happy to have even one life saved as a result of passage of SB 364.

CHAIR ROKEBERG said that it seems to him that the Alaska Supreme Court has issued a clear mandate to the legislature [to resolve this issue]. He observed that in order to do that, it is imperative that any forthcoming legislation be drafted in such a way as to withstand legal challenge.

CHAIR ROKEBERG announced that SB 364 would be held over.

ADJOURNMENT

Number 1134

There being no further business before the committee, the House Judiciary Standing Committee meeting was adjourned at 6:07 p.m.