MAINE SUPREME JUDICIAL COURT
SITTING AS THE LAW COURT

Law Court Docket No. CUM-17-494

Mabel Wadsworth Women's Health Center; Family Planning Association of Maine d/b/a Maine Family Planning and Primary Care Services; and Planned Parenthood of Northern New England,

Plaintiffs – Appellants

v.

Ricker Hamilton, Commissioner of the Department of Health and Human Services,

Defendants – Appellees

APPEAL
FROM THE CUMBERLAND COUNTY SUPERIOR COURT

BRIEF OF AMICI CURIAE MAINE PUBLIC HEALTH ASSOCIATION, REBECCA C. HUNT, MD, FACOG, ANDREA PELLETIER, MD, MPH, CAROLINE FOUST-WRIGHT, MD, MBA FACOG, ANN ADAMS, MD, KATHRYN E. SHARPLESS, MD, PHD, FACOG, JULIA BROCK, MD, JENNIFER POFAHL, MD, FACOG, LANI GRAHAM, MD, MPH

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Constitutional Provisions

Statutes

Regulations

Books & Articles

STATEMENT OF INTEREST OF AMICI CURIAE[1]

The Maine Public Health Association ("MPHA") is a statewide, non-profit membership organization representing nearly 650 Maine public health professionals. The mission of MPHA is to improve and sustain the health and well-being of all Maine residents through evidence-based health promotion, disease prevention, and the advancement of health equity through advocacy, education, community connection, and coalition-building. MPHA's interest in this issue is based on our commitment to assuring that all Maine residents have the opportunity to lead healthful lives, including equitable treatment and access to healthcare. Rebecca C. Hunt; MD, FACOG; Andrea Pelletier, MD, MPH; Caroline Foust-Wright, MD, MBA FACOG; Ann Adams, MD; Kathryn E. Sharpless, MD, PhD, FACOG; Julia Brock, MD; Jennifer Pofahl, MD, FACOG; and Lani Graham, MD, MPH are physicians with deep personal and professional interest in advancing evidence-based policies and practices impacting women's

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[1] MPHA, along with Rebecca C. Hunt; MD, FACOG; Andrea Pelletier, MD, MPH; Caroline Foust-Wright, MD, MBA FACOG; Ann Adams, MD; Kathryn E. Sharpless, MD, PhD, FACOG; Julia Brock, MD; Jennifer Pofahl, MD, FACOG; and Lani Graham, MD, MPH, are referred to collectively herein as the "Amici."

reproductive health in Maine. This group of individual practitioners is made up of leaders, educators, and experts in the fields of public health, obstetrics, and gynecology. These physicians recognize the importance of eliminating financial barriers to health care for low-income women, which is the basis of their decision to join on this *amici curiae* brief.

This brief seeks to assist the Court by addressing the issues faced by, and elucidating the factual and legal considerations relevant to, MaineCare–enrolled and –eligible women and their physicians, who determine that an abortion procedure is the best health care decision for the patient, but are denied coverage for the procedure under application ofrules promulgated by the Maine Department of Health and Human Services ("DHHS," or the "Department").

INTRODUCTION

Abortion is an essential part of comprehensive reproductive health care for women. A woman's ability to access abortions is a necessary component of public health, particularly the health of rural and socioeconomically disadvantaged women. In Maine, nearly half of all pregnancies are unintended, and of those unintended pregnancies, approximately 28% end in induced abortions. Kost, Katherine *Unintended*

Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002, at 8 (Guttmacher Inst. 2015). The rates of unintended pregnancy and abortion are higher among low-income women. Finer, Lawrence B. et al., *Unintended pregnancy in the United States: incidence and disparities, 2006*, 84 CONTRACEPTION 478, 481 (Nov. 2011). Unfortunately, abortion care is so marginalized in this country that it is one of the only essential health care service not offered by a woman's usual health care provider or health care system. Am. Coll. of Obstetricians & Gynecologists, Comm. on Health Care for Underserved Women, *Increasing Access to Abortion*, COMM. OPINION NO. 613, at 2 (Nov. 2014; reaff. 2017) (hereinafter "ACOG Opinion No. 613"). Limiting access to care is a significant public health concern, in part because when women face barriers to accessing abortion care, they often resort to unsafe means to terminate a pregnancy, increasing their risk of maternal death and other complications. *Id.*

I. Reasons women seek abortion care

Many factors influence or necessitate a woman's decision to have an abortion. They include, but are not limited to, contraceptive failure, barriers to contraceptive use and access, rape, incest, intimate partner violence, fetal anomalies, and exposure to medications that adversely affect

embryo and fetal development. *See id.* A woman, in consultation with her health care provider, may choose to have an abortion because a pregnancy has caused or could exacerbate medical conditions, a mental health condition, or issues associated with a substance abuse disorder. (A. 86 ¶¶ 84-86.) Furthermore, in a 2012 study on the reasons underlying a woman's decision to seek an abortion, 40% of respondents cited financial reasons as a basis for their decision not to carry their pregnancy to term. *See* Briggs, M. Antonia et al., *Understanding why women seek abortions in the US*, 13 BMC WOMEN'S HEALTH, at 5 (July 5, 2013).

II. The significance of socioeconomic status on women's reproductive health

The intersection of poverty and how financial resources can, and often do, limit a women's ability to access abortion services is acutely felt in Maine. Approximately 13.5% of Maine's population lives in poverty — the second highest rate in New England and tenth in the nation. *See* U.S. Census Bureau, *2012-2016 American Community Survey 5-Year Estimates*, tbl. DP03. Since 2001, Maine has lost a net of 37,000 middle-class jobs that have largely been replaced by low-wage jobs in the service, retail, and tourism

sectors[2]. Mynal, James, Me. Ctr. for Economic Policy, *State of Working Maine 2017*, at 8 (2017). Women, along with people of color, experience this declining rate of economic opportunity more acutely than their male counterparts, and Maine women who work full-time, year-round earn on average 84 cents for every dollar their male peers earn. Catherine Hill et al., Am. Assoc. of Univ. Women, *The Simple Truth about the Gender Pay Gap*, at 8 (Spring 2018 ed.). In addition, women living in poverty are more likely to suffer from serious psychological stress, and the combination of financial strain and emotion stress faced by low-income women can significantly delay (and often prevents) them from seeking timely medical care. *See* Weissman, Judith et al., Nat. Ctr. for Health Statistics, *Serious psychological distress among adults: United States, 2009–2013*, NCHS DATA BRIEF, NO. 203, at 1-2 (May 2015). The dangerous stress of poverty can be so adverse to women's health that it can be "medical justification enough for a woman to decide it is in her best interest to obtain an abortion." (A. 249-259.)

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[2] Low-wage jobs are defined as those in which the median wage for the occupation is less than 75% of the statewide median wage in that year, high-wage jobs are those paying above 125% of the statewide median income. *See* Mynal, *supra*, at 26.

III. The MaineCare Ban places an impermissible and detrimental restriction on the patient-physician relationship and a women's right to do what is best for her individual health

Women enrolled in MaineCare — Maine's Medicaid program — will have nearly all pregnancy-related care -- including prenatal care, delivery, and miscarriage care – covered. *See* (A. 14; 52-53 ¶¶ 39-41); 10-144 C.M.R. ch. 101(II), § 90.04-4(B). However, abortion and abortion-related care is only covered in the event the pregnancy is the result of rape, incest, or an abortion is necessary to save the life of the mother. 10-144 C.M.R. ch. 101(II), § 90.05-2 (the "MaineCare Ban"). This limitation mirrors the policy adopted by the federal government in what is commonly referred to as the Hyde Amendment, Pub. L. 96–123, § 109, 93 Stat. 926, but inconsistent with the Maine Legislature's pronouncement that the State may not restrict "a woman's exercise of her private decision to terminate a pregnancy," 22 M.R.S.A. § 1598(1). Put simply, the MaineCare Ban is a significant economic barrier that restricts a MaineCare-enrolled and -eligible woman from exercising her legal right to access abortion care and a rule that is in direct conflict with express legislative policy codified in statute.

Not only does the MaineCare Ban effectively restrict a woman's right to obtain an abortion, the regulation impermissibly infringes on the

fundamental elements of the patient-physician relationship. The American Medical Association's Principles of Medical Ethics provides that a patient has a right "[t]o make decisions about the care the physician recommends and to have those decisions respected," as well as "receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment." AMA Counsel on Ethics & Judicial Affairs, *Code of Medical Ethics of the American Medical Association*, Opinion E-1.1.3(b), (d) (2017). The MaineCare Ban makes it difficult for providers serving MaineCare-enrolled and -eligible women to follow these core tenets of the patient-provider relationship. It represents a restriction that is unique to abortion care providers and is neither evidence-based, nor ethical, and fails to protect a woman's reproductive health and best interests. ACOG Opinion No. 613, at 2. When restrictions like the MaineCare Ban are placed on abortion access, it has a direct impact on whether or not abortions are safely obtained. *Id.* at 5.

In short, these restrictions should be rejected as inapposite to sound public policy declared by the Legislature, as well as established medical principles.

IV. The MaineCare Ban provides no economic benefit to the State of Maine and operates as a *de facto* abortion ban for MaineCare-eligible women

The ban on funding the majority of abortions sought by MaineCare–eligible and –enrolled women in Maine provides no fiscal benefit to the State. In 2010, 74.7% of unplanned births in Maine were publicly funded, compared with 68% nationally. Sonfield, Adam et al., *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy Related Care: National and State Estimates for 2010*, at 11 (Guttmacher Inst. 2015). The cost for publically funded births from unintended pregnancies in 2010 totaled $58,200,000, with $14,600,000 of the cost born exclusively by the State of Maine. Sonfield, Adam et al., *The Public Costs of Births Resulting from Unintended Pregnancies: National and State-Level Estimates*, 43 PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH, at 98 (2011). DHHS admits that it is not aware of any data showing that the MaineCare Ban provides any fiscal benefit to the State. *See* (A. 88 ¶ 95.) Despite this lack of financial benefit to State of Maine, and the State's neutrality as to birth or abortion as codified in Maine's Reproductive Privacy Act, 22 M.R.S.A. § 1598 (the "RPA"), DHHS's rule serves as a *de facto* abortion ban, favoring birth among MaineCare-eligible

and –enrolled women. In fact, studies show that 18-37% of Medicaid-eligible women who carried their pregnancies to term would have had an abortion instead if Medicaid coverage had been available. (A. 239.) Given Maine's stated public policy of not favoring birth over abortion, MaineCare-eligible and –enrolled women should be able to make the health care decisions that are best for them regardless of financial ability to pay. The Department's continued enforcement of the MaineCare Ban makes that practically impossible.

STATEMENT OF PROCEDURAL HISTORY AND FACTS

The Amici adopt the Procedural History as set forth by Appellants, *see* (Blue Br. 3), and also adopt the Joint Statement of Material Facts filed by Appellants and Appellees with the Superior Court, *see* (A. 79-263.)[3]

SUMMARY OF THE ARGUMENT

DHHS has unlawfully and unconstitutionally adopted its MaineCare Ban, an administrative rule that purports to prohibit state Medicaid coverage for abortion, except where the pregnancy threatens a woman's

[3] This Brief of Amici Curiae adopts the defined terms used by Appellants, namely the following: Maine's Department of Health and Human Services ("DHHS" or the "Department"); Maine's Reproductive Privacy Act, 22 M.R.S.A. § 1598 ("RPA"); 10-144 C.M.R. ch. 101(II), § 90.05-2 (the "MaineCare Ban" or the "Ban"); Pub. L. 96–123, § 109, 93 Stat. 926 (the "Hyde Amendment").

life or is the result of rape or incest. The MaineCare Ban is in direct conflict with an enactment of the Maine Legislature declaring that "[i]t is the public policy of the State that the State not restrict a[n adult] woman's exercise of her private decision to terminate a pregnancy before viability." 22 M.R.S.A. § 1598(1). Moreover, the MaineCare Ban is not rationally related to any legitimate governmental interest.

The seemingly benign rationale for the MaineCare Ban offered by DHHS, and erroneously accepted at face value by the Superior Court, is DHHS's announced desire to "achieve consistency and compliance" with federal law. (A. 37.) However, this announced rationale proves to be an attempt of an executive agency to adopt and enforce a federal policy disfavoring abortion despite Maine's legislatively-announced governmental interest in neutrality on this issue.

The Hyde Amendment prevents federal reimbursement for abortion, except where the pregnancy threatens a woman's life or is the result of rape or incest. The purpose of the Hyde Amendment is to "prevent abortions." *See*, *e.g.*, *McRae v. Califano*, 491 F.Supp. 630, 641 (E.D.N.Y. 1980) *rev'd on other grounds sub nom. Harris v. McRae*, 448 U.S. 297 (1980). The Supreme Court of the United States, in a narrow 5-4 decision, accepted this as a

legitimate governmental purpose and held that it is a permissible imposition on a woman's right to an abortion because the federal government can use its spending power to advance a public policy favoring birth over abortion. *Harris*, 448 U.S. at 313. Appellants ably argues that *Harris* was wrongly decided, and that this Court should join the many states whose highest courts have determined that their state constitutions do not permit the government to use its spending power in such an intrusive manner. Likewise, the Amicus Brief filed by Marshall J. Tinkle ably argues that the protections unique to the Maine Constitution make the strained federal constitutional analysis underpinning the Hyde Amendment insufficient to save the MaineCare Ban. This brief joins in those arguments, but focuses more specifically on what it means that DHHS is attempting to achieve "consistency and compliance" with a federal public policy disfavoring abortion when the Maine Legislature has codified a State public policy of neutrality.

Here, the Department's justification that their adoption of the Ban was to ensure "compliance" with federal law, *see* (A. 37), is a red herring. DHHS concedes that nothing in federal law *requires* the State to limit abortion coverage under MaineCare to those instances for which federal

dollars are available. *See* (A. 37-38.) Indeed, many states—including every other state that has a legislative policy of neutrality similar to Maine's—have federally compliant Medicaid programs that fund abortion. Here, DHHS improperly relies upon the justification that the MaineCare Ban is appropriate because it merely provides "consistency" with federal law. While the language of the MaineCare Ban is consistent with federal law, it is blatantly inconsistent with Maine's legislative policy of neutrality, which controls here. By adopting the MaineCare Ban, DHHS usurped the role of the legislature, setting public policy and unlawfully infringes on access to abortion care in Maine. Rather than administer MaineCare in a rational manner in line with the Legislature's pronouncement, the Department has advanced a policy that is clearly intended to prevent abortion access by Maine's low-income women, which is exemplified by the following simple syllogism:

1. *Major premise*: The purpose underlying the Hyde Amendment is to prevent abortion;
2. *Minor premise*: The purpose of the MaineCare Ban is achieve consistency with the Hyde Amendment;
3. *Conclusion*: The purpose of the MaineCare Ban is to prevent abortion.

Thus, the logical conclusion of DHHS's stated purpose of the MaineCare Ban is to adopt the very public policy rejected by the Maine Legislature. As a matter of law, this is both unlawful and unconstitutional. Under the Maine Constitution and Administrative Procedure Act, it is the legislature, not DHHS, which has authority to adopt public policy. This is particularly true where, as here, the public policy regards the degree to which the State seeks to intrude on its citizen's constitutionally protected guarantees of liberty, safety, and equality. *See* Me. Const. art. I, §§ 1, 6-A.

Studies show that 18-37% of Medicaid-eligible women who carried their pregnancies to term would have had an abortion instead if Medicaid coverage had been available. (A. 239.) Thus, the facts here demonstrate that the MaineCare Ban has led to the exact results the Legislature sought to prevent by enacting 22 M.R.S.A. § 1598(1): more women have been forced to carry unintended, unwanted pregnancies to term. This is governmental restriction in-fact of a woman's right to an abortion, in direct contravention to the public policy of the State for neutrality regarding a woman's constitutionally protected choice of reproductive health care. Thus, this is both unlawful and unconstitutional.

The federal government has used its spending power to take a constitutionally-suspect position disfavoring abortion. In a narrow, heavily criticized decision, the United States held that it was nonetheless constitutionally permissible for the government to take a spending-power position disfavoring the exercise of a woman's constitutionally protected right to manage her own reproductive health. The Maine Legislature has rejected that policy, making the express finding that it is not a legitimate governmental interest in the State of Maine. DHHS has nonetheless adopted such a restrictive and prejudiced policy through the enactment of the MaineCare Ban. Purposely or not, the MaineCare Ban operates as an improper adoption of a federal policy that puts a governmental thumb on the scale when a woman is weighing a health care decision with her provider. This violates Maine's separation of powers, exceeds DHHS's authority under the APA, and is not rationally related to any governmental interest. Accordingly, this Court should declare the MaineCare Ban void and unenforceable.

ARGUMENT

I. The RPA is a Legislative Declaration of Neutrality on Abortion Decisions That Does More Than Restate Federal Constitutional Restrictions on State Action.

The Maine Legislature has declared that "[i]t is the public policy of the State that the State not restrict a woman's exercise of her private decision to terminate a pregnancy before viability . . ." 22 M.R.S.A. § 1598(1). Maine is one of only six states that have enshrined in statute such protection from state actions putting a thumb on the scale of a woman's decision as to whether or not to terminate a pregnancy. *See, e.g.*, Cal. Health & Safety Code §§ 123462, 123466 (West 2018) ("The state may not deny or interfere with a woman's right to choose or obtain an abortion . . .."); Conn. Gen. Stat. Ann. § 19a-602(a) (West 2018) ("The decision to terminate a pregnancy prior to viability of the fetus shall be solely that of the pregnant woman in consultation with her physician."); Haw. Rev. Stat. § 453-16(c) (West 2018) ("The State shall not deny or interfere with a female's right to choose or obtain an abortion . . .."); Md. Code Ann., Health-Gen. § 20-209(b) (West 2018) ("the State may not interfere with the decision of a woman to terminate a pregnancy …."); Wash. Rev. Code Ann. §§ 9.02.100, 9.02.110, 9.02.140, 9.02.160 (West 2018) ("it is the public policy of the state of

Washington that . . . the state shall not deny or interfere with a woman's fundamental right to choose or refuse to have an abortion; and [t]he state shall not discriminate against the exercise of these rights in the regulation or provision of benefits, facilities, services, or information."). Of these six states, however, Maine is the only one that prohibits state Medicaid funding for abortion services by adopting the parameters of the Hyde Amendment.

The Superior Court erred when it determined that the Maine Legislature's use of the word "restrict" meant that the RPA was not a true legislative statement of neutrality, but instead left DHHS free to adopt the federal policy favoring birth over abortion. (A. 28-29.) The Superior Court analogize the language of the RPA to the analysis in *Harris v. McRae. Id.* In other words, the Superior Court essentially held that Maine's RPA was surplusage that did nothing more than restate *Harris v. McRae*.[4] However,

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[4] The Superior Court also relies on *Anderson v. Town of Durham*, 2006 ME 39, 895 A.2d 944, for the proposition that discriminatorily funding one constitutionally protected choice but not another does not burden or inhibit the unfunded choice in a constitutionally significant manner. (A30). In the first place, the analogy is inapt because, unlike the establishment clause, the Constitution contains no anti-abortion-equivalent phrase favoring birth over abortion. But even to the extent the analogy were apt, the distinction in *Anderson* has been called into doubt by *Trinity Lutheran Church of Columbia, Inc. v. Comer*, 137 S. Ct. 2012, 2017 (2017) (rejecting the

for a better analogy, this Court should review what other courts have said about similar reproductive privacy acts enacted in the other five states.

No other state has interpreted its reproductive privacy act to be a restatement of federal constitutional law. Instead, these courts have recognized that reproductive privacy laws provide protections that stand in addition to protective state constitutional provisions. For example, the California RPA was adopted in 2002, long after the California Supreme Court had interpreted Article I, section 1 of the California Constitution as providing that "all women in this state—rich and poor alike—possess a fundamental constitutional right to choose whether or not to bear a child." *Comm. To Defend Reprod. Rights v. Myers*, 256, 625 P.2d 779 (Cal. 1981). But as a California Court explained, California's Reproductive Privacy Act of 2002 stands "[i]n addition to these constitutional protections." *Church v. Rouillard*, No. 2:15-cv-02165-KJM-EFB, 2016 WL 3688422, at **2–3 (E.D. Cal., July 11, 2016) (emphasis added).

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argument that "merely declining to extend funds to Trinity Lutheran does not *prohibit* the Church from engaging in any religious conduct or otherwise exercising its religious rights.").

Similarly, Connecticut courts have held that funding restrictions on abortions violate the state constitutional guarantees of equal protection and due process, notwithstanding a then-codified state policy enacted "to protect and preserve human life from the moment of conception." *Doe v. Maher*, 515 A.2d 134, 150, 157 (Conn. Super. Ct. 1986) (referring to Conn. Gen. Stat. Ann. § 53-31b (repealed 1990, P.A. 90-113, § 4)). But in 1990, Connecticut repealed section 53-31a and adopted new public policy by and through a reproductive privacy law, Conn. Gen. Stat. Ann. § 19a-602(a), and Connecticut judges have subesquently understood this to mean that in addition to the constitutional protections announced in *Mahar*, "the right to an abortion was, and remains, statutorily protected with minimal restrictions." *State v. Courchesne*, 998 A.2d 1, 151 (Conn. 2010) (*Schaller, J.*, concurring in part and dissenting in part).

Likewise, the Maryland courts have highlighted the protective nature of that state's RPA, recognizing that a woman's right to terminate her pregnancy "is a matter of important public policy in this State, flowing not only from this Court's considered view <u>but as well from statute</u> . . . precluding the State from interfering with the decision of a woman to terminate her pregnancy" *Lab. Corp. of Am. v. Hood*, 911 A.2d 841, 850–51

(Md. 2006) (emphasis added) (citing Md. Code Ann., Health-Gen. § 20-209 (West 2018)).

Also analogous is the case of *Doe v. Celani*, No. S81-84CnC (Vt. Super. Ct., Chittenden Cty., May 26, 1986), where the Vermont Superior Court noted that "[u]nlike some other jurisdictions, Vermont does not prefer childbirth over abortion as a matter of public policy." *Id.* slip op. at 4. The Court went on to hold unconstitutional a Vermont agency's failure to reimburse for abortions not subject to federal reimbursement under the Hyde Amendment, and along the way noted that "[a]n administrative desire to synchronize funding with that reimbursable with federal funds, simply because a federal statute restricts reimbursement, is not within the authorized bounds when action is not expressly permitted by the enabling legislation." *Id.* at 15. The Court clearly saw that the regulation "d[id] nothing but further a social policy couched in terms of favoring childbirth over abortion at the expense of the health of the mother, which is antithetical to the medical assistance purposes" of Vermont law. *Id.* at 16.

Similarly here, DHHS is not free to adopt the public policy of some "other jurisdiction" (i.e., the federal government) favoring birth over abortion. This Court must recognize Maine's RPA for what it is: a

statement of neutrality that, unlike some other jurisdictions, does not permit the Maine government to prefer childbirth over abortion. Once that public policy was declared by the Legislature, it cannot be changed or contravened by an executive agency. Even assuming that the Maine's Constitution would permit the Legislature to favor birth over abortion,[5] unless or until it does so, the codified policy statement of neutrality necessarily informs both the statutory and constitutional authority of the Department.

II. The MaineCare Ban Exceeds the Rulemaking Authority of DHHS and, therefore, is Invalid as a Matter of Law.

Under Maine's Administrative Procedure Act ("APA"), a rule is invalid if it exceeds the agency's statutory authority or if the rule is arbitrary and capricious or contrary to law. 5 M.R.S.A. § 8058. The MaineCare Ban exceeds the Department's rulemaking authority and, as discussed in more detail below, is arbitrary and capricious.

The Maine Legislature has clearly and unambiguously declared that the State of Maine does not take a position in favor of either birth or

[5] Appellants and other Amici ably argue that the Maine Constitution would prevent the Legislature from adopting this contrary policy.

abortion. 22 M.R.S. § 1598(1).[6] By contrast, the federal government, through the Hyde Amendment, deliberately attempts to curb abortion by prohibiting federal Medicaid funds from covering abortion unless the pregnancy is life-threating or the result of rape or incest. *See* Pub. L. 96–123, § 109, 93 Stat. 926. The stated goal of DHHS (i.e. achieving consistency with federal law) means that Maine law also favors birth over abortion in violation of the State's policy of neutrality.

In upholding the federal policy disfavoring abortion, the United States Supreme Court held that the "refusal to fund protected activity, without more, cannot be equated with the imposition of a 'penalty' on that activity." *Harris v. McRae*, 448 U.S. 297, 317 n.19. However, as the Connecticut Superior Court held in *Doe v. Maher*, "the dilemma in which poor women find themselves as a result of the failure to fund medically necessary abortions is the 'more.'" 515 A.2d 134, 155 (Super. Ct. 1986); *see also id.* n.45 (recognizing that "*appropriate* medical care is the mark of the Medicaid program" (emphasis in original))

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[6] The exception provided for in section 1597-A relates to consent for a minor and is not relevant to this case.

Physicians and indigent women across the State find themselves facing this very dilemma. "The primary purpose of the Department's role in MaineCare is to administer a program that provides families and individuals with insufficient income resources access to necessary medical services." *Doane v. Dep't of Health & Human Services*, 2017 ME 193, ¶ 39, 170 A.3d 269 (*Jabar, J.*, dissenting) (citations omitted). Low-income women rely on MaineCare to pay for the expenses associated with their reproductive health care, including abortions. *See* (A. 51-53 ¶¶ 35-41.) The program is designed to support this reliance, for "the purpose of these assistance programs is to place the indigent in a position to obtain services on an equal basis with those more fortunate people who can obtain these services for themselves." *Celani*, S81-84-CnC, slip op. at 10. The Department has the authority to "issue rules and regulations considered necessary and proper for the protection of life, health and welfare, and the successful operation of the health and welfare laws." 22 M.R.S.A. § 42(1). But by enforcing the MaineCare Ban—a rule that creates a clear and unequivocal financial barrier to health care access only affecting low-income women—the Department is placing the health and well-being of these women at risk with no policy or fiscal rationale for doing so. *See* ACOG Opinion No. 613,

at 2; *see also* Jerman, Jenna et al., *Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States*, 49 PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 95, 98 (Apr. 10, 2017) (explaining that women facing barriers to abortion services delay seeking care, experience negative mental health outcomes, and may consider ending their pregnancy on their own using unsafe and potential lethal methods). In other words, rather than placing disadvantaged women in a position where they can access services available to those more fortunate, the MaineCare Ban injects coercive financial incentives favoring childbirth and restricts women's access to abortion. Not only is this an overreach of DHHS's authority to establish state policy, it violates the equal protection and due process rights of a group of individuals merely because they happen to be of a certain gender and socioeconomic status.

a. The MaineCare Ban is an overreach by the Department, representing an unconstitutional usurpation of Maine legislative policy that must be rejected as a matter of law.

DHHS is charged with administering MaineCare. *See* 22 M.R.S.A. § 3173; *see also* 24–A M.R.S.A. § 6911. To carry out this charge, "[t]he [D]epartment is authorized and empowered to make all necessary rules and regulations *consistent with the laws of the State* for the administration of"

the MaineCare program. 22 M.R.S.A. § 3173 (emphasis added). The promulgation of a rule that directly contradicts the announced public policy of the State of Maine—as the Ban does here—violates not only the APA, it also runs afoul of the separation of powers provided for in the Maine Constitution.

Maine's constitution provides that all of the powers of government are divided into legislative, executive, and judicial departments. Me. Const. art. 3, § 1. "[N]o person or persons, belonging to one of these departments, shall exercise any of the powers properly belonging to either of the other . . ." Me. Const. art. III, § 2. The legislature has the "full power to make and establish all reasonable laws and regulations for the defense and benefit of the people of this State." Me. Const. art. IV, Pt. 3, § 1. The executive branch—which includes the Department—is tasked with taking care that the laws are faithfully executed. Me. Const. art. V, Pt. 1, § 12. The power of the legislature is considered "absolute"; it is permitted to act as it deems appropriate and is limited only where specifically restricted by the Constitution. *Sawyer v. Gilmore*, 109 Me. 169, 83 A. 673, 678 (1912). The power of the executive branch, on the other hand, is far more circumscribed. The executive may "exercise only the powers enumerated

and conferred upon [it] by the Constitution and as such as necessarily implied therefrom." *Id*. The governor's powers "are only what are specially given him by the constitution or necessarily inferable from powers clearly granted." *In re Opinion of Justices*, 72 Me. 542, 546 (1881); *see also Opinion of the Justices*, 460 A.2d 1341, 1354 (Me. 1982).

The Maine Constitution allows the executive branch to be involved in the legislative process in only a very limited capacity. It is permitted "to give information and recommend measures," and to convene the legislature. Me. Const. Art V, Pt. 1, §§ 9, 13. Nothing in the Constitution authorizes the executive to adopt or change public policy; that responsibility is left exclusively to the legislature. *See Burkett v. Youngs*, 135 Me. 459, 199 A. 619 (1938) (holding that "[i]f the Constitution or statutes speak upon a subject the public policy of the state is necessarily fixed to that extent."). Likewise, the legislative determination of public policy within constitutional limitations is conclusive upon the courts. *City of Belfast v. Belfast Water Co.*, 115 Me. 234, 98 A. 738 (1916).

Here, by promulgating a rule that directly contradicts the public policy adopted by the Maine Legislature, the Department has unlawfully usurped the power of the legislature and violated the separation of powers

provided for in the Maine Constitution. By effectively changing the public policy of the state from remaining neutral on a woman's right to terminate a pregnancy to one favoring carrying the pregnancy to term, DHHS's Ban violates Article III of the Maine constitution by "exercis[ing] power properly [and exclusively] belonging to" the legislature. The MaineCare Ban also violates the Article V of the Maine Constitution and the well-established rule that executive power is limited to those powers enumerated in the Constitution. Because this ban violates the separation of powers established by the Maine Constitution, and because its enactment is not linked to a power specifically enumerated to the executive branch in the Constitution, this ban is unconstitutional, and its enforcement should therefore be permanently enjoined.

b. The MaineCare Ban is arbitrary and capricious under the APA and fails rational basis review under Due Process.

Just as the MaineCare Ban exceeds the rulemaking authority of DHHS, it is "arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law" because its only purpose is to prevent abortions. 5 M.R.S.A. § 8058(1). Although regularity of the administrative agency in enacting rules is presumed, this presumption is overcome because the Ban

is "unreasonable, lacks a factual basis, or lacks support in an evidentiary record" for anything other than the impermissible purpose of preventing abortions. *Conservation Law Found., Inc. v. Dep't Of Envtl. Prot.*, 2003 ME 62, ¶ 38, 823 A.2d 551.

As discussed in more detail above, the only rationale that DHHS has provided for the MaineCare Ban is to "achieve consistency and compliance with federal law." (A. 37.) This rationale is insufficient because "[a]n administrative desire to synchronize funding with that reimbursable with federal funds, simply because a federal statute restricts reimbursement, is not within authorized bounds when that action is not expressly permitted by the enabling legislation." *Celani*, No. S81-84CnC, slip op. at 15. Furthermore, there is no factual basis to support the MaineCare Ban. When the State denies funding for an abortion, it is forced to spend more money on prenatal, postnatal, childbirth, and pregnancy complications costs, *see* 42 U.S.C. § 1396a(a)(10)(A)(i)(III); 42 C.F.R. § 435.116(b) ("The agency must provide Medicaid to pregnant women . . ."), and women who are denied medically necessary abortions face significant health risks and are more likely to experience adverse psychological outcomes, *see* Briggs, M. Antonia et al., *Women's Mental Health and Well-being 5 Years After Receiving or Being*

Denied an Abortion: A Prospective, Longitudinal Cohort Study, 74 JAMA PSYCHIATRY, at 171 (Feb. 2017).

Similarly, the MaineCare Ban fails rational basis review under Maine's Due Process clause because it bears no rational relation to any independent public policy goal. As the Supreme Judicial Court of Massachusetts held, by "injecting coercive financial incentives favoring childbirth into a decision that is constitutionally guaranteed to be free from governmental intrusion (this restriction) deprives the indigent woman of her free to choose abortion over maternity, thereby impinging on the due process liberty right recognized by *Roe v. Wade*." *Moe v. Sec'y of Admin. & Fin.*, 417 N.E.2d 387, 402 (Mass. 1981).

In *Doe v. Celani*, the Vermont Superior Court held that Vermont Department of Social Welfare, Medicaid Policy M61 (1980), which limited abortion coverage in a manner consistent with the Hyde Amendment, "failed to establish any rational basis for the regulation as its only necessary consequence was to favor childbirth over abortion." No. S81-84-CnC, slip op. at 5-7. The Vermont Court explained that such a regulation "impinges directly on the constitutionally guaranteed right to safety [and] increases the danger to health by precluding access by indigents to a

necessary medical procedure." *Id.* at 11. Like the Vermont regulation, the MaineCare Ban interferes with the patient-physician relationship and precludes poor women across the State from accessing a necessary medical procedure. It not only fails to comply with the RPA, it favors birth over a woman's right over her own reproductive health care, well-being, and personal safety.

Moreover, while the State may not be obligated to pay for the exercise of constitutional rights, "it is equally true that once a government chooses to dispense funds, it must do so in a nondiscriminatory fashion, and it certainly cannot withdraw benefit for no reason other than that a woman chooses to avail herself of a federally-granted constitutional right." *Women's Health Ctr. of W. Virginia, Inc. v. Panepinto*, 446 S.E.2d 658, 666 (W.Va. 1993). And while "[t]he Legislature need not subsidize any of the costs associated with child bearing, or with health care generally[,] . . . once it chooses to enter the constitutionally protected area of choice, it must do so with genuine indifference." *Moe*, 417 N.E.2d at 402. By enforcing the Ban, the Department is unlawfully "weigh[ing] the options open to the pregnant woman by its allocation of public funds," *id.*, circumventing the State's express statutory policy of neutrality found under the RPA. Where

the State of Maine does not benefit from the MaineCare Ban, and it threatens the health and welfare of MaineCare-eligible women who are forced to carry unwanted pregnancy to term, driving up costs to the MaineCare program, no rational basis can be found to uphold the Ban. Therefore, this Court should rule the MaineCare Ban is an unconstitutional ban on the due process of MaineCare-eligible and -enrolled women and the Department should be permanently enjoined from its enforcement.

CONCLUSION

Purposeful or not, the MaineCare Ban operates in Maine as an unauthorized and improper application of the federal thumb-on-the-scale of a woman's health care decision making and the evidence shows that this governmental thumb is destructively effective. For the reasons stated above, this Court should reverse the Superior Court's decision and find that MaineCare Ban is a unlawful, unconstitutional regulatory provision and permanently enjoin DHHS from continuing its enforcement.

Dated: March 23, 2018

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CERTIFICATE OF SERVICE

I, Melissa A. Hewey, hereby certify that on this 23rd day of March 2018, I filed one (1) original and nine (9) copies of the foregoing Brief of Amici Curiae with the Clerk of Court and further certify that two (2) copies of the foregoing were mailed by U.S. Mail, first class, postage prepaid to the addressed as follows, and have also provided a courtesy copy by electronic mail.

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ADDENDUM

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January 25, 2018

VIA HAND DELIVERY

Hon. Matthew Pollack
Clerk
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Clerk's Office
205 Newbury Street
Portland, Maine 04101

Re: *Mabel Wadsworth Women's Health Center et al. v. Commissioner of Department of Health and Human Services (CUM-17-494)*

Dear Mr. Pollack:

On behalf of Appellants, I hereby consent to the filing of all amicus curiae briefs in support of either party or neither party.

If you have any questions, please do not hesitate to contact me.

Respectfully,

Zachary L. Heiden

cc: Susan P. Herman, DAG

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February 23, 2018

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Re: *Mabel Wadsworth Women's Health Center et al v. Commissioner of Department of Health and Human Services*
Docket No. Cum-17-494

Dear Mr. Pollack:

This is to inform the Court that Appellee Commissioner of Department of Health and Human Services consents to the filing of all amicus curiae briefs in support of either party or neither party.

Thank you for your attention to this matter.

Sincerely,

Halliday Moncure
Assistant Attorney General

HM/lsf
cc: Zachary L. Heiden, Esq.
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