IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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26 MD 2019

ALLEGHENY REPRODUCTIVE HEALTH CENTER, *et al.*,
Petitioners,

v.

PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES, *et al.*,
Respondents.

Brief of Amici Curiae Eight Women Harmed by Abortion in Support of Respondents

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

INTEREST OF AMICI

Amici are eight women who were harmed by their abortions. Many of them were manipulated by those closest to them, often their boyfriends and fathers, to abort their babies. Rather than experiencing freedom through their abortions, their regret at having undergone an abortion or multiple abortions has been the defining harm in their lives. They wish to bring perspective to this Court through their stories. Their experience illustrates how additional funding will not result in freedom and improved outcomes but more women being manipulated by others to have abortions—abortions that too often result in physical and emotional harm.

SUMMARY OF ARGUMENT

The Pennsylvania Supreme Court returned the case to this Court to determine 1) whether for purposes of the Equal Rights Amendment there is "evidence of a compelling state interest in" the Medicaid restriction on elective abortion funding and whether "less intrusive methods" are available, and 2) whether for purposes of Equal Protection under Article I, Section 26, the Medicaid restriction is justified after a

"means-end review." *Allegheny Reprod. Health Ctr. v. Pa. Dep't of Hum. Servs.*, 309 A.3d 808, 947 (Pa. 2024).

The Commonwealth's interests in women's health as well as protecting and promoting the lives of those in Pennsylvania (including unborn lives) are compelling. As such, the Medicaid restriction is constitutional not only under the Equal Rights Amendment but under Article I, Section 26, no matter what level of scrutiny is applied to that provision. Therefore, it is not necessary for this Court to address whether there is a constitutional right to abortion that would trigger strict scrutiny under Article I, Section 26. Further, the doctrine of constitutional avoidance counsels against addressing this unnecessary issue.

Conversely, if this Court were to determine that the Commonwealth's interests in protecting women's health as well as protecting and promoting life are not compelling, this Court need not and should not opine on whether there is a fundamental right to abortion. If the Medicaid prohibition already violates the Equal Rights Amendment, any further constitutional analysis would violate the doctrine of constitutional avoidance.

ARGUMENT

I. The Commonwealth's Interests in Advancing Women's Health and Promoting Life are Compelling.

Petitioners describe abortion in unrealistic terms. Amici's stories demonstrate the tragic repercussions that too many women experience as a result of abortion. That harm is not merely anecdotal but is demonstrated through studies, which show that when states pay for elective abortions, women's physical and emotional health suffers. The Commonwealth's interest in avoiding these harms to women is compelling. Likewise, states have a compelling interest in protecting and promoting the lives of its citizens, including unborn lives.

A. The Commonwealth has a Compelling Interest in Women's Health, Which is Adversely Affected by Publicly Funded Abortion.

1. Women Who Obtain an Abortion Through Pressure and Misinformation Experience Recurring Emotional and Mental Trauma.

It is not uncommon for women to report feeling high levels of pressure or coercion from partners or family members when facing an unplanned pregnancy. In fact, studies show consistently that a majority

of women feel pressure or coercion in the decision to obtain an abortion.[1] Coerced or pressured abortions are also linked to a variety of mental health problems that can persist years and even a lifetime.[2] Amici consistently experienced some degree of coercion or pressure to have an abortion from others in their families, especially their male partners. In all cases, they reported varying degrees of physical and psychological harm that substantially impacted their daily lives. A brief description of their stories are as follows:

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[1] *See* Tessa Cox, *et al.*, *Study: Many Women Who Had Abortions Felt Pressured By Others*, May 25, 2023 [hereinafter "*Pressured by Others*"], *available at* https://lozierinstitute.org/study-many-women-who-had-abortions-felt-pressured-by-others/ (survey showing that 70% of women who had abortions described them as coerced, pressured, or inconsistent with their own values or preferences); *see also* Charlotte Lozier Institute, *New Study: Rapid Repeat Pregnancy Most Common Among Women Who Have Abortions,* July 8, 2021, *available at* https://lozierinstitute.org/new-study-rapid-repeat-pregnancy-most-common-among-women-who-have-abortions/ (reporting that up to 64% of women feel pressured by others into unwanted abortions, and only a minority of aborted pregnancies are unwanted); Vincent M. Rue, *et al.*, *Induced Abortion and Traumatic Stress: A Preliminary Comparison of American and Russian Women*, October 1, 2004, *available at* https://medscimonit.com/abstract/index/idArt/11784 (reporting that nearly two-thirds of American women felt pressured by other people to obtain an abortion).

[2] *See Pressured by Others*, at 1 (women report "heightened levels of stress, feelings of grief, intrusive thoughts, and disruption of daily life" that exist for years from the added pressure to obtain an abortion); *see also* David C. Reardon, *et al.*, *Whose Choice? Pressure to Abort Linked to Worsening of Subsequent Mental Health*, February 7, 2023 [hereinafter "*Whose Choice?*"], *available at* https://lozierinstitute.org/whose-choice-pressure-to-abort-linked-to-worsening-of-subsequent-mental-health/ (women report negative emotions including interference with daily life, work relationships, intrusive thoughts, flashbacks to the abortion, frequent feelings of grief, loss, and sadness about the abortion, and increased levels of stress when answering questions about the abortion).

T.C. was a victim of statutory rape when she was 11 years old, and became pregnant the first time she had sex. T.C.'s mother was a drug addict who trafficked T.C. to pay for her drug habit, and she forced T.C. to have an abortion with T.C.'s first pregnancy. T.C. has suffered since with anger, shame, and guilt over being forced into the "choice" of aborting her baby; she would have elected adoption over abortion had she truly been able to make this choice. Even today, T.C. believes that even though she was a child victim of rape, "no one has the right to take away the choice of a baby" to have life.

M.H. was very young. When she became pregnant, her boyfriend gave her the ultimatum that "it was him or the baby." When M.H. was at the abortion clinic, she was told by the abortion clinic that "it would all be over soon." However, the trauma never ended, and the emotional and mental pain from this procedure was accompanied with regret that she still carries with her daily. M.H. is now committed to redirecting women from abortion so they do not experience the same immense harm.

J.C. became pregnant at the age of 14 and her sister told her to get an abortion. She went to a Planned Parenthood clinic and was advised by the counselor that her baby was just a "blob of tissue," and that "this was the best decision for her since she was so young and had her whole life ahead of her." The counselor suggested that if anyone from Planned Parenthood needed to contact her at home, they had a "code" to conceal this information from her parents. After this abortion, J.C. became pregnant again at age 15, delivered her first child, then became pregnant a third time at 15-and-a-half, but aborted this child as well. J.C. instinctively believed abortion was wrong and has suffered for years from the trauma of this "choice" that instead resulted in years of emotional bondage.

M.N. moved to Los Angeles to connect with an old boyfriend who used cocaine, but got caught up with a culture of fornication, which resulted in two unplanned pregnancies that culminated in two abortions. Before the second pregnancy, the boyfriend promised her that if she became pregnant again, he would marry her. However, when she became pregnant, the boyfriend pressured her to get an abortion and never married her. M.N. still regrets these choices and believes that "as women, we instinctively know that we are made to give life, not take it."

J.P. was raised in a strict Catholic family, but nevertheless became sexually active as she grew older. In her first sexual encounter with a man, she became pregnant, and the man rejected her once he thought he would have to be a father. Abortion was presented as an option, which she chose, but was still rejected by this man. Since that decision, J.P. has suffered from depression.

S.W. was molested as a child, and she had her first of three abortions at the age of thirteen. In her first pregnancy, her mother took her to the doctor and asked if they could "take it down." S.W. recalled "feeling the suction" and "something ripped out of her body." S.W. became pregnant again and had two more abortions. Although S.W. has four children now, she feels guilt and regret about the other children she aborted.

E.S. had an abortion at the age of 23. She was a recent college graduate at the time, and the father of the child was seeing another woman who was also pregnant with his child. The father told E.S., among other things, that she would be a "horrible mother" if she chose to keep the baby, so she had an abortion. At first she felt relief, but the guilt returned, along with profound feelings of anger

> and depression, decreased productivity at her job, low self-esteem, and the realization that the only party who benefited from this decision was the child's father. E.S. had developed a substance abuse disorder brought on by her need to self-medicate the depression and guilt, but has sought help through counseling.
>
> M.D. was not raised to have any particular viewpoint about abortion; she simply thought abortion was what a woman did to escape the responsibility of raising a child. M.D., however, found herself in a position where she had two abortions performed, but later developed a personal conviction that what she did was wrong and currently suffers from the guilt and shame of her decision.

2. Funding Abortions Increases Abortion Rates.

Abortion rates are directly related to abortion funding. It is estimated that since the federal Hyde Amendment was enacted in 1976 with the purpose of banning federal funding of abortions except for rape, incest, and the life of the mother, 2,566,968 lives in the United States have been saved, which includes 119,899 lives in Pennsylvania alone.[3] However, the Hyde Amendment does not prevent taxpayer funding of abortion when states use their own tax dollars to cover abortion through their Medicaid program.

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[3] *See* Michael J. New, *Hyde @ 40: Analyzing the Impact of the Hyde Amendment with July 2020 and June 2023 Addenda,* June 27, 2023 [hereinafter "*Hyde @ 40*"], *available at* https://lozierinstitute.org/hyde-40-analyzing-the-impact-of-the-hyde-amendment-with-july-2020-and-june-2023-addenda/.

Specifically, when the State of Kansas was considering whether to expand its Medicaid funding in 2019 to include elective abortions, a number of studies were reviewed which found statistically significant evidence that abortion rates went up after Medicaid funding was increased.[4]

Conversely, when taxpayer money was not available to pay for abortions, the abortion rate decreased. The State of North Carolina funded abortions through a state abortion fund rather than Medicaid, but when the abortion fund was depleted of money, there were statistically significant decreases in the abortion rate and statistically higher birth rates months later.[5]

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[4] Among these studies, a Guttmacher Institute literature review identified 18 peer-reviewed studies that analyzed the impact of state Medicaid funding on the incidence of abortion. These methodologically diverse studies utilized abortion data from a variety of sources. Overall, of the 18 studies they considered, 15 found statistically significant evidence that abortion rates went up after Medicaid funding was increased. *See* Michael J. New, *An Analysis of How Medicaid Expansion in Kansas Will Affect Abortion Rates*, February 19, 2020 [hereinafter "*Medicaid Expansion in Kansas*"], *available at* https://lozierinstitute.org/an-analysis-of-how-medicaid-expansion-in-kansas-will-affect-abortion-rates/#_edn48.

[5] *Id.*; *see also* P.J. Cook *et al.*, *The Effects of Short-term Variation in Abortion Funding on Pregnancy Outcomes*, April 18, 1999, *available at* https://pubmed.ncbi.nlm.nih.gov/10346355//.

The Guttmacher literature review shows that the "best research" indicates that limits on Medicaid funding reduce the number of abortions. They state the following:

> [T]he best studies . . . used detailed data from individual states and compared the ratio of abortions to births before and after Medicaid restrictions took effect. These found that 18-37 percent of pregnancies that would have ended in Medicaid funded abortions were carried to term when funding was no longer available.[6]

Considering these studies collectively, the lack of funding influences about a quarter of Medicaid-eligible women to continue pregnancies.[7]

3. Funding Abortions Results in Repeat Abortions.

Statistics show that women who obtain an abortion during their pregnancies, are more likely to have repeated abortions. A study conducted of 7,388,842 pregnancy outcomes occurring in 17 states that paid for elective abortions between 1999-2014 showed that women whose pregnancy ended in abortion were much more likely to have subsequent

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[6] *See supra Hyde @ 40*, at 19 (citations omitted). According to Guttmacher, the methodologically strongest studies found that Medicaid funding of abortion increased the abortion rate for women on Medicaid from 22% to 58%. *See also Medicaid Expansion In Kansas*, *supra* note 4, at 7 (citations omitted).

[7] *Id.*; *see also* Stanley K. Henshaw, *et al.*, *Restrictions on Medicaid Funding For Abortions: A Literature Review*, June 2009, *available at* https://www.guttmacher.org/sites/default/files/report_pdf/medicaidlitreview.pdf.

pregnancies end in abortion.[8] Whereas women who had births or natural fetal losses were likely to have subsequent births rather than abortions.[9]

These trends are more pronounced when an abortion occurs with a first pregnancy, as the first pregnancy abortion maintains a strong association with the likelihood of another abortion in subsequent pregnancies. A longitudinal cohort study conducted of individuals eligible for Medicaid benefits which funded elective abortions between 1999 and 2015, found that the majority of women who had an abortion were more likely to have a subsequent abortion.[10] Across all ages and demographics,

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[8] *See* James Studnicki, *et al.*, *Pregnancy Outcome Patterns of Medicaid Eligible Women, 1999 - 2014: A National Prospective Longitudinal Study*, July 31, 2020 [hereinafter "*Pregnancy Outcome Patterns*"], *available at* https://journals.sagepub.com/doi/full/10.1177/2333392820941348.

[9] *Id.*

[10] In the study, women ages 16 in 1999 were organized into three cohorts based on first pregnancy outcome—abortion, birth, and natural loss. It was determined that women who had an abortion in their first pregnancy were more likely than those in the birth cohort to experience another abortion rather than a birth or natural loss, and less likely to experience a live birth or natural loss, for every subsequent pregnancy. The pattern is reversed for the women in the birth cohort. Compared to the birth cohort, the abortion cohort had 1.35 times as many pregnancies, 4.31 times as many abortions, 1.53 times the natural losses, but only 0.52 times the births. The total distribution of all pregnancy outcomes for each cohort was as follows: abortion (abortion 65%, birth 28%, natural loss, 7%); birth (abortion 20%, birth 73%, natural loss 7%); natural loss (abortion 22%, birth 39%, natural loss 39%). Of the abortion cohort, 37.1% had no births. In contrast, 73.6% of the birth cohort had no abortions. *See* James Studnicki, *et al.*, *The Enduring Association of a First Pregnancy Abortion With Subsequent Pregnancy Outcomes: A Longitudinal Cohort Study*, October 11, 2022, *available at* https://journals.sagepub.com/doi/10.1177/23333928221130942?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed.

abortion is associated with additional pregnancies and additional abortions, whereas births and natural fetal losses are associated with subsequent births rather than abortions.

4. Increased Abortion Rates and Repeat Abortions Subject Women to an Increased Risk of Physical and Mental Harm.

These repeated abortions expose women to medical complications such as hemorrhage and infection, which is the major cause of maternal mortality.[11] For low income women in particular, there is an elevated risk of cardiovascular disease risk with a history of pregnancy loss (either abortion or natural loss).[12]

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[11] *Pregnancy Outcome Patterns, supra* note 8.

[12] *See* Maka Tsulukidze, *et al.*, *Effects of Prior Reproductive Losses on Risk of Cardiovascular Diseases Within Six Months of a First Live Birth*, March 13, 2024, *available at* https://pubmed.ncbi.nlm.nih.gov/38525098/. A prospective longitudinal study examined medical records between 1999 and 2014 for Medicaid beneficiaries born after 1982 who lived in a state that funds all reproductive health services, including abortion. A history of pregnancy loss was associated with 38% higher risk of cardiovascular disease (CVD) diagnosis in the period observed. After controlling for history of diabetes hyperlipidemia, age, year of first pregnancy, race, state of residence, months of eligibility, number of pregnancies, births, number of losses before and after the first live birth, exposure to any pregnancy loss was associated with an 18% increased risk of CVD. These findings show that pregnancy loss is an independent risk factor for CVD, especially for diseases more chronic in nature. Maka Tsulukidze, *et al.*, *Elevated Cardiovascular Disease Risk in Low-Income Women With A History of Pregnancy Loss*, May 25, 2022, *available at* https://openheart.bmj.com/content/9/1/e002035.long.

Abortions are additionally associated with a significantly higher need for mental health services.[13] The need for mental health services becomes worse when women are pressured into having abortions. These women are "significantly more likely to blame their abortions for their decline in mental health, increased disruptions in their daily lives, and more frequent episodes of grief and loss."[14] A history of pregnancy loss—not only a natural loss but also from abortion—is a risk factor for postpartum psychiatric illness, and this risk is heightened by a co-occurring history of mental health treatment.

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[13] *See* James Studnicki, *et al.*, *A Cohort Study of Mental Health Services Utilization Following a First Pregnancy Abortion or Birth*, June 15, 2023, *available at* *https://www.dovepress.com/a-cohort-study-of-mental-health-services-utilization-following-a-first-peer-reviewed-fulltext-article-IJWH*. Participants beginning in 1999 at age 16 were followed until 2015 and assigned to one of two cohorts based on first pregnancy outcome—either birth or abortion. Outcomes for these women varied between outpatient mental health visits, inpatient mental health admissions, and hospital days of stay. Women with first pregnancy abortions, compared to women with births, had a higher risk and likelihood of experiencing all three mental health outcome events in the transition from pre to post pregnancy outcome periods. A first pregnancy abortion, compared to a birth, was linked to a significantly higher need for mental health services following the first pregnancy. The risks attributable to abortion was notably higher for inpatient rather than outpatient mental health services. In fact, there was greater mental health utilization before the first pregnancy outcome for birth cohort women, which shows that a pre-existing mental health history cannot be used to explain mental health problems following abortion, rather than the abortion itself.

[14] *See Whose Choice?*, *supra* note 2; David C. Reardon, *et al.*, *Effects of Pregnancy Loss on Subsequent Postpartum Mental Health: A Prospective Longitudinal Cohort Study*, February 23, 2021, *available at* https://www.mdpi.com/1660-4601/18/4/2179.

5. The Commonwealth Has a Compelling Interest in Avoiding These Adverse Health Effects.

The state has a compelling interest in protecting women's health. The United States Supreme Court has described a compelling interest as one "of the highest order." *Wisconsin v. Yoder*, 406 U.S. 205, 215 (1972). Even under *Roe v. Wade*, the United States Supreme Court recognized a compelling state interest in the health of the mother at the end of the first trimester.[15] In overruling *Roe*, the *Dobbs v. Jackson Women's Health Org.* Court never rejected *Roe's* determination that the government has a compelling interest in protecting women's health, but rather, among other things, rejected *Roe's* use of a trimester framework.[16]

Other high courts have also recognized a compelling interest in protecting women's health. *See, e.g.*, *Hodes & Nauser, MD's, P.A. v. Stanek*, 551 P.3d 62, 79 (Kan. 2024) ("protecting maternal health may be a compelling state interest"); *Wrigley v. Romanick*, 988 N.W.2d 231, 242

[15] *Roe v. Wade*, 410 U.S. 113, 163 (1973) ("With respect to the State's important and legitimate interest in the health of the mother, the 'compelling' point, in light of present medical knowledge, is at approximately the end of the first trimester.").
[16] *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 270-75 (2021) ("Not only did this [trimester] scheme resemble the work of a legislature, but the Court made little effort to explain how these rules could be deduced from any of these sources on which constitutional decisions are usually based.").

(N.D. 2023) ("The State has a compelling interest in protecting women's health and protecting unborn human life."); *Simat Corp. v. Ariz. Healthcare Cost Containment Sys.*, 56 P.3d 28, 34 (Ariz. 2002) (preservation and protection of women's health is a compelling interest); *Planned Parenthood of Middle Tenn. v. Sundquist*, 38 S.W.3d 1, 17 (Tenn. 2000) (finding that because Tennessee's constitution states that government is "instituted for [the] peace, safety and happiness" of its citizens, Tenn. Const. Art. I, § 1, "the State clearly has a compelling interest in maternal health from the beginning of pregnancy"). It is evident that numerous states and the United States Supreme Court place a high priority on the protection, promotion, and preservation of women's health, and such interest is compelling.

B. The Commonwealth has a Compelling Interest in Protecting and Promoting the Lives of Those in Pennsylvania, Including Unborn Lives.

The government's compelling interest in the protection and promotion of life is broad. It is so fundamental that the first section of the first Article of our Commonwealth's constitution recognizes our "inherent and indefeasible" right to "enjoy[] and defend[] life[.]" PA. CONST. Art. I, §1. We see that interest at play in a variety of contexts. *See*, *e.g.*,

Commonwealth v. Nixon, 563 Pa. 425, 435, 761 A.2d 1151, 1156 (2000) (recognizing a compelling interest in the "very life of an unemancipated minor"); *see also D.P. v. G.J.P.*, 636 Pa. 574, 586, 146 A.3d 204, 211 (Pa. 2015) (compelling interest "in safeguarding children from various kinds of physical . . . harm"); *accord State v. Melchert-Dinkel*, 844 N.W.2d 13, 22 (Minn. 2014) (recognizing "a compelling interest in preserving human life"); *In re Schuoler*, 723 P.2d 1103, 1108 (Wash. 1986) (recognizing a compelling interest in "the preservation of life"): *People v. Jensen*, 586 N.W.2d 748, 756 (Mich. Ct. App. 1998) (compelling interest in "preserving the life of its citizens").

Our Commonwealth's compelling interest in life extends to the unborn. Even under *Roe v. Wade*, 410 U.S. 113 (1973), the United States Supreme Court recognized a compelling interest in protecting life, albeit only after the point of viability. "With respect to the State's important and legitimate interest in protecting life, the 'compelling' point is viability." *Id.* at 164. In overruling *Roe*, the United States Supreme Court in *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2021), never rejected *Roe's* determination that the State has a compelling interest in protecting life in the womb, but instead rejected *Roe's* use of the viability

rule to make *any* distinction as to the value of prenatal life. *See Dobbs*, 597 U.S. at 279. Ultimately, viability provides no meaningful legal distinction—whether evaluating the state's compelling interest in life or whether evaluating the constitutionality of other laws.[17] At root, viability is an unhelpful concept because it depends too greatly upon external conditions such as the state of medical technology at the time of the pregnancy.[18]

Our Commonwealth has asserted an interest in all unborn life. *See* Crimes Against the Unborn Child Act, 18 Pa.C.S. §§ 2601-09. Moreover, it has asserted that interest in the most compelling way in stating that it "places a supreme value upon protecting human life." Abortion Control

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[17] Even before *Dobbs*, the Pennsylvania Supreme Court rejected any distinction between pre- and post-viable life in upholding the constitutionality of Pennsylvania's Crimes Against the Unborn Child Act, 18 Pa.C.S. §2601 *et seq*. In *Commonwealth v. Bullock,* 590 Pa. 480, 913 A.2d 207 (Pa. 2006), the Pennsylvania Supreme Court held that the fetal homicide statute properly extended criminal liability for the murder, voluntary manslaughter, or aggravated assault of an unborn child without any distinction made for the viability of the unborn child. *Id*. at 212 ("It is also clear that, by defining unborn child to include all stages of gestation . . . the General Assembly intended to eliminate any viability requirement."). *See also Commonwealth v. Bullock*, 2005 PA Super. 16, 868 A.2d 516, 523 (Pa. Super. 2004) ("[I]t is clear that the legislature intended to protect unborn children from the moment of fertilization. The viability of the fetus . . . is irrelevant.").

[18] *Dobbs*, 597 U.S. at 274-78; *see also Bullock*, 913 A.2d at 213 ("[T]o accept that a fetus is not biologically alive until it can survive outside of the womb would be illogical, as such a concept would define fetal life in terms that depend upon external conditions, namely, the existing state of medical technology (which, of course, tends to improve over time.")).

Act § 2(b)(4), 18 Pa.C.S. § 3202(b)(4). Likewise, since the *Dobbs* decision, other high courts have recognized a compelling interest in protecting unborn life. *See*, *e.g.*, *Planned Parenthood S. Atl. v. State*, 892 S.E.2d 121, 132 (S.C. 2023) ("indisputable" compelling interest in "protecting the lives of unborn children"); *Wrigley v. Romanick*, 988 N.W.2d 231, 242 (N.D. 2023) (compelling interest in "protecting unborn human life").

It is unsurprising that there should be a compelling interest in unborn life as the government's interest in life and human dignity is broad—even extending to end of life issues. In upholding Washington's ban on physician assisted suicide in *Washington v. Glucksberg*, 521 U.S. 702 (1997), the United States Supreme Court relied on *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990) to determine that Washington had an "*unqualified* interest in the preservation of human life." *Glucksberg*, 521 U.S. 728 (emphasis added). The Court rejected the argument that the State only has an interest in "preserving the lives of those who can still contribute to society and enjoy life," *id.* at 729 (*quoting* Brief for Respondents 35, n.23), and noted that through the assisted-suicide ban, the State of Washington was insisting that "*all* persons' lives, from *beginning to end*, regardless of physical or mental condition,

are under full protection of the law," *id*. at 730 (emphasis added).

The Court further recognized that it is a crime in almost every state, as well as every Western democracy, to assist in a suicide[19] due to the "longstanding expression of the States' commitment to the protection and preservation of *all* human life."[20] The prohibitions against assisting suicide never contained exceptions for those who were at or near death, and furthermore made no exceptions relating to the individual's quality, length, or value of life.[21]

The United States Supreme Court in *Glucksberg* finally gave special consideration to protecting society's most vulnerable individuals from committing suicide, including those who were mentally ill, the poor, elderly, and physically disabled.[22] In fact, the Court noted that the State's assisted suicide ban "reflects and reinforces its policy that the lives of the

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[19] *Id*. at 711 (*citing Compassion in Dying v. Washington,* 79 F.3d 790, 847 (CA9 1996)) (indicating that forty-four states, the District of Columbia, and two territories prohibit or condemn suicide); *see also Rodriguez v. British Columbia (Attorney General)*, 107 D.L.R. (4th) 342, 404 (Can. 1993) ("[A] blanket prohibition on assisted suicide . . . is the norm in western democracies," and discussed assisted suicide provisions in Austria, Spain, Italy, the United Kingdom, the Netherlands, Denmark, Switzerland, and France.).

[20] *Id*. at 710-11 (emphasis added) (*quoting Cruzan*, 497 U.S. at 280) ("The States – indeed, all civilized nations – demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide.").

[21] *Id*. at 714-15.

[22] *Id*. at 730-32.

terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy."[23] Similarly, the Commonwealth of Pennsylvania provides increased penalties to protect vulnerable classes in its crime against aiding in suicide, as there are sentencing enhancements if the decedent is under the age of eighteen, is intellectually disabled, or suffers from autism.[24]

In summary, the Commonwealth's interest in promoting and preserving the dignity of life is broad. Because this interest is so broad and compelling, it extends to the unborn.

II. Because the Commonwealth's Interests are Compelling, the Medicaid Restrictions Not Only Survive the Equal Rights Amendment Analysis but also the Equal Protection Analysis Under Article I, Section 26.

Not only are the Commonwealth's interests in women's health as well as promoting and protecting life compelling, the Medicaid restriction on elective abortion funding is the least restrictive means to accomplish those interests. Women's health is immediately undermined when women experience an unwanted abortion or any abortion resulting in

[23] *Id.* at 733.
[24] *See* Causing or Aiding in Suicide, 18 Pa.C.S. § 2505(c)(1).

physical and emotional harm. Free government elective abortions necessarily result in the ability for more boyfriends and fathers to manipulate women into an unwanted abortion. And free government elective abortions are shown to result in more repeat abortions leading to increased physical and emotional harms. The Medicaid restriction on elective abortion funding is narrowly related to the interest in avoiding these harms since these harms are otherwise unavoidable.

The same is true for the Commonwealth's interest in protecting and promoting life. Once the government is in the business of paying for elective abortions, that compelling interest is necessarily undermined. Therefore, since the Medicaid restriction on elective abortion funding is narrowly tailored to a compelling governmental interest, the Medicaid restrictions survive strict scrutiny applicable to the Equal Rights Amendment claim.

While the Supreme Court left some doubt as to the appropriate level of scrutiny applicable to Equal Protection under Article I, Section 26, this Court need not determine the level of scrutiny, because if the Medicaid restrictions are narrowly tailored to a compelling government interest, the Medicaid restrictions already survive the most exacting standard.

III. This Court Should Not Address Whether There is a Constitutional Right to Abortion.

Petitioners ask this Court to declare a fundamental right to reproductive autonomy protected by Pennsylvania's constitution. But there is no reason to address whether there is a constitutional right to abortion (in addition to the statutory right) that triggers strict scrutiny under Article I, Section 26 if the Medicaid restrictions already survive strict scrutiny.

Conversely, even if this Court concludes that the Medicaid restrictions are not narrowly tailored to a compelling government interest, this Court should stop its analysis with the Equal Right Amendment, because there is no need to determine whether there is an alternative means to strike down the law. This case rises and falls on whether the Medicaid restrictions are narrowly tailored to a compelling governmental interest, not on whether there is a fundamental, constitutional right to abortion.

Both logic and the doctrine of constitutional avoidance dictate the same result. Typically, that doctrine involves interpreting statutes to avoid unnecessarily reaching constitutional issues. But the point is avoiding constitutional questions that need not be answered. *See In re*

"B", 482 Pa. 471, 477, 394 A.2d 419, 421-22 (Pa. 1978) ("Ordinarily, when faced with . . . both constitutional and non-constitutional questions, we will make a determination on non-constitutional grounds, and avoid the constitutional question if possible."). This court "prefer[s] to avoid constitutional questions when possible." *J.P. v. HHS*, 170 A.3d 575, 584 (Pa. Commw. Ct. 2017).

> Under the doctrine of constitutional avoidance, "we ought not to pass on questions of constitutionality . . . unless such adjudication is unavoidable." *Spector Motor Service v. McLaughlin*, 323 U.S. 101, 105, 65 S. Ct. 152, 89 L. Ed. 101, (1944); *see also In re Stevenson*, 608 Pa. 397, 12 A.3d 273, 275 (Pa. 2010) (*per curiam*) ("[A]s a general matter, it is better to avoid constitutional questions if a non-constitutional ground for decision is available.").

Commonwealth v. Collins, 2022 PA Super. 195, 286 A.3d 767, 773 (Pa. Super. 2022).

In summary and most plainly, "The Court should not decide a constitutional question unless absolutely required to do so." *Commonwealth v. Veon*, 637 Pa. 442, 456, 150 A.3d 435, 443 (Pa. 2016). Here, of course, there are multiple constitutional grounds for analysis, but after determining whether the Medicaid restriction is narrowly tailored to a compelling governmental interest for analyzing the one

constitutional issue, the Equal Rights Amendment, an analysis that will identically satisfy or fail strict scrutiny under Article I, Section 26, it is unnecessary to address yet a third constitutional issue, one not included in the mandate of the Supreme Court—whether there exists a constitutional right to abortion.

CONCLUSION

There is no more compelling interest than protecting and promoting the lives of those in our state—including unborn life. Likewise, the Commonwealth has an interest of the highest magnitude in protecting and promoting the health of the women of our state. Because the Medicaid restriction on elective abortion funding is narrowly tailored to address these compelling governmental interests, it survives strict scrutiny. This court need not and should not rule on whether there is a constitutional right to abortion since it is unnecessary for the Court's consideration of the constitutionality of the Medicaid restriction.

Respectfully submitted,

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CERTIFICATE OF WORD COUNT

I certify pursuant to Pa.R.A.P. 531 that this brief does not exceed 7,000 words.

CERTIFICATE OF COMPLIANCE WITH RULE 127

I certify that this filing complies with the provisions of the Public Access Policy of the Unified Judicial System of Pennsylvania: Case Records of the Appellate and Trial Courts that require filing confidential information and documents differently than non-confidential information and documents.

CERTIFICATE OF SERVICE

I hereby certify that the foregoing document was served upon the parties via PACFile.

Respectfully submitted,

*/s/*Cheryl Lynn Allen
CHERYL LYNN ALLEN