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# An Analysis of State and Nationwide Legislation on Women's Healthcare Access in Virginia

Lillian Singer

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**An Analysis of State and Nationwide Legislation on Women's Healthcare Access in  
Virginia**

A thesis submitted in partial fulfillment of the requirements for the degree of Bachelor of  
Science with Honors in Interdisciplinary Studies from The College of William & Mary

by

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# **An Analysis of State and Nationwide Legislation on Women's Healthcare Access in Virginia**

## **Chapter 1: Introduction**

### **Background and Study Design**

The issue of abortion access has been a contentious one long predating 1973, when the passage of *Roe v. Wade* brought it to the fore of U.S. political discourse. Incorporating moral, religious, financial, and political interests, the debate launched by this landmark case marked only the beginning of decades of advances and reversals in the legislation surrounding abortion access. Once a deeply personal and private matter, abortion has risen to the top of political agendas on both sides of the political aisle, and become one of the prominent civil rights issues of this century.

Virginia serves as an optimal case study for examining legislation on this complex topic. It has a long history as a battleground state in national and statewide elections, making it a hotbed for political activism regarding controversial issues. In addition, Virginia is the birthplace of many of the court cases that eventually arrived at the Supreme Court. These cases have helped to shape the policy surrounding reproductive healthcare at a national level in a lasting way. Today, much of Virginia's state legislation regarding abortion services is as divisive as the *Roe v. Wade* ruling was at its outset, making the topic of women's healthcare one that many politicians pointedly avoid, and only a select few leverage greatly.

Former Governor Bob McDonnell, for example, spent much of his time in office working to amend Virginia statutes and introduce bills that were aligned with the conservative values for which he was elected. One of the last pieces of legislation he

signed regarding reproductive healthcare was Senate Bill 924, colloquially known as TRAP – Targeted Regulations of Abortion Providers. The bill was signed in 2011 as emergency safety legislation, and as a result, was implemented immediately (Guttmacher Institute, 2015). Senate Bill 924 outlines architectural and administrative requirements that hold clinics performing upwards of five first-trimester abortions per month to the same safety and reporting standards as hospitals (Guttmacher Institute, 2015).

However, the bill addresses abortion care as a singular service, when in reality, there are multiple methods of abortion depending upon stage of gestation. While the more widely controversial form of abortion is surgical – particularly late-term, high-risk abortions in the second trimester – nearly 90% of all abortions in the U.S. are performed in the first trimester and involve no surgery at all (Guttmacher Institute, 2014). In fact, one third of abortions occurs prior to six weeks gestation, and are typically medical abortions, which consist of taking two pills over the span of 48 hours (Guttmacher Institute, 2014).

For those first trimester abortions that *are* surgical, the service is currently categorized as an outpatient procedure, which formerly meant that it could be performed in ambulatory care facilities under the same regulations as other outpatient operations. Currently, women who undergo surgical abortions experience complications at a rate of less than 0.3%, making first-trimester abortions nearly fourteen times safer than childbirth (Gold & Nash, 2013). This raises the question: whose safety are the terms of SB 924 designed to protect? And in this light, are these terms constitutional?

These were the initial questions I intended to answer when I began researching TRAP and its impacts on reproductive healthcare access in Virginia. Finding answers has

required me to reach far beyond simple statistics or putative facts associated with abortion care. The investigation points to a complex web of politics, misinformation, and extensive red tape that have all muddied the waters of reproductive healthcare policymaking.

This investigation began in the summer of 2013, at the height of TRAP's implementation, and as its effects were being felt fully by women's clinics throughout the state. I wanted to understand these regulations and their consequences for Virginia clinics, were there any to be had. Additionally, I wanted to explore the projections made by current abortion providers and public interest group representatives concerning the future of abortion access in Virginia. My questions were basic in the beginning:

- What is TRAP?
- How are TRAP regulations being implemented?
- Have the TRAP regulations achieved the envisioned goals?
- What are the anticipated long-term effects of TRAP provisions on women's clinic services?

I sought to depict the landscape surrounding abortion access as both a still-shot of 2013 and as a panorama stretching from 1973 to the present, including all pertinent legislation that has shaped abortion access nationwide. I recognized that I would need to examine abortion access at the macrocosmic level of Supreme Court cases and also examine Virginia as a microcosmic lens for viewing abortion access.

First, I examined abortion access on a legislative level, giving an historical background of the topic on a state and national level, as well as describing in detail Senate Bill 924 and its inception. Though parts of this work are outside the scope of this

thesis, and thus have been excluded from this manuscript, all data collected in my first year of research has helped me to narrow my focus on the topics to be presented in this paper.

Based on my sense of how the law began to take shape and whom the key players were in the discussions that shaped outcomes, I decided that I should interview physicians, public advocacy group representatives, Planned Parenthood administrators, and those whose involvement was faith-based. I undertook these field interviews in order to investigate the effects of information and misinformation and to examine the perspectives of: (1) those who have participated directly in public debates about abortion access; (2) those who are involved in providing abortions and related services; and (3) those who have participated in the creation and passage of TRAP laws. In order to gain firsthand exposure to some of the complex realities of seeking abortion services, I also volunteered with a local task force that escorts patients at clinics. This helped to keep me grounded in the realities of issues that might otherwise have been approached too abstractly.

My review of the emergence of the legislation and the discussions surrounding it strongly suggested that understanding the details of this critical piece of legislation would require understanding diverse narratives about the law, abortion services, and the clinics that provide them. It became clear that I would also need to understand what information is available, its reliability, and whether and how people access such information. This includes examining how information (and misinformation) is diffused in our communities, and determining how much knowledge the general public really has on such an important issue.



In order to present my findings as coherently as possible, I have organized this manuscript in the following manner: to begin, I will give an overview of TRAP laws and their impact on abortion access. I will also examine TRAP and its consequences from three perspectives: the creation and implementation of TRAP laws, TRAP laws in the context of PPACA, and interviews conducted at two time points. Next, I will examine abortion access as it relates to PPACA, drawing from other research on the matter and on the perspectives of those interviewed, to paint a clearer picture of its specific impact on Virginia. I will conclude with my discussion of the interview and data analysis process for both sets of interviews. The first round of these interviews was largely exploratory, but through analysis of the resulting data I was able to identify specific themes. The second round of interviews allowed me to explore those themes through more focused interview questions, and revealed points of comparison between the two points in time.

### **Overview of Legislation**

To properly conclude my introduction of the succeeding chapters and segue into my discussion of TRAP, I will provide a brief overview of the legislation to be discussed. My early study of TRAP legislation prompted me to explore a second, equally important piece of legislation: the Patient Protection and Affordable Care Act, better known as the PPACA or ACA. Passed in March 2010 with sponsorship from President Obama, this bill represents one of the largest comprehensive healthcare reform measures in the history of the United States (The Henry J. Kaiser Family Foundation, 2013). Its primary goals include making healthcare more accessible and affordable, and decreasing the rates of uninsured Americans by mandating the creation of more coverage options (The Henry J. Kaiser Family Foundation, 2013). While this piece of legislation is far-reaching in its

effects on all aspects of healthcare provision and access, my study focuses on the interplay between PPACA and TRAP concerning reproductive healthcare and primary care access in Virginia.

Through PPACA and its mandates and subsidies, more Virginians are slated to receive insurance coverage through their employers or through private insurance plans. Proponents believe that the net effect will generate public good: more individuals will be insured, the economy will be bolstered by the increase in Medicaid and Medicare spending, and states' long-term productivity will increase by having healthier citizens. However, this perspective overlooks some possible setbacks of PPACA.

For example, one problem that some anticipate is the growing number of Virginians with access to primary care, and the declining number of clinics where they would be able to receive services – as a result of TRAP laws. Clinics that cannot meet architectural requirements of TRAP currently provide primary care services to many women. Their elimination will, thus, affect the supply of services in Virginia's healthcare system. This outcome illustrates both a potential unintended consequence of PPACA and a possible conflict between the goals of PPACA and the effects of TRAP laws.

Among other things, I learned through my interviews that TRAP would create new burdens for hospitals in meeting the needs of patients currently served by women's clinics. Many hospitals are already overburdened as they meet the needs of both insured and non-insured patients. The potential for influxes of unknown numbers of new patients who have benefits through PPACA arrangements is considerable: some studies project they will create significant problems for many hospitals and their related services (Hwang, Liao, Griffin, & Foley, 2012). For example, one estimate suggests that as many

as 75% of emergency department visits are considered “non-urgent,” and emergency room overcrowding is present, on average, 35% of the time in most major hospitals (Hwang, Liao, Griffin, & Foley, 2012). The loss of clinics through TRAP regulations, then, is likely to increase the demand placed on overworked hospitalists, and may overpopulate facilities meant for true cases of emergency.

As TRAP leads to the gradual closure of clinics across the state, the numbers of non-urgent emergency room visits is expected to grow. At present, roughly four percent of all abortions are performed in hospitals, largely due to the availability of physicians in private clinics or Planned Parenthoods who can perform the service outside of a hospital setting (Wyler, 2013). The number of such abortions likely would increase and there would be additional unintended consequences from this concentration of hospital-based care as well. The true extent of TRAP’s effects is yet to be seen.

Another consequence of this reduction in abortion access lies in the provision of less controversial services, which may be lost as well. The clinics in question are responsible for providing to thousands of women the exact services that *prevent* unwanted pregnancies. These are the same services that have contributed to the steadily declining abortion rate in both Virginia and the U.S. as a whole. This includes education on safe sex practices, prescription of contraception, and family planning counseling (Planned Parenthood Federation of America, 2014). The loss of these services may not only lead to an increase in the number of unwanted pregnancies, but also heighten the number of unnecessary emergency room visits due to the secondary effects of these losses. This might include treatment of STIs or implantation of contraceptive devices,

neither of which would be considered urgent by any hospital's standards (Planned Parenthood Federation of America, 2014).

Ultimately, this thesis aims to shed light on legislation that is shaping healthcare services around us every day, but it will also speak to a greater individual need – awareness. Though Senate Bill 924 and PPACA are objects of interest for me, they are only a sampling of the great volume of legislation and literature that impacts us all, but about which we remain largely uninformed. It is my hope that through education on this topic, action may follow, and we may all be more conscious and involved citizens for it.

## Chapter 2: Targeted Regulations of Abortion Providers

### What is TRAP?

TRAP was the original focal point of the research that has produced this thesis. It is regarded by some as a contentious bill that has had and will have substantial effects on reproductive healthcare services in Virginia. TRAP, or “targeted regulations of abortion providers,” is more formally known as Senate Bill 924, which was sponsored by Senator Ryan T. McDougle (R) during the 2011 Virginia General Assembly (Hospitals, nursing homes, etc.; regulations required of Board of Health, 2011). It was then signed by Governor Bob McDonnell as emergency safety legislation later that year (Greenier & Glenberg, 2014). The bill consists of two types of laws that impose on medical facilities that perform more than five abortions per month the same safety and licensing standards as hospitals (Hospitals, nursing homes, etc.; regulations required of Board of Health, 2011).

Originally, the bill was passed as “An Act...relating to regulation of hospitals, nursing homes, and certified nursing facilities” (Hospitals, nursing homes, etc.; regulations required of Board of Health, 2011). All regulations listed in this bill pertain explicitly to these institutions, and it was only in its final presentation before the House and the Senate that Delegate Kathy Byron (R) amended the bill (Hospitals, nursing homes, etc.; regulations required of Board of Health, 2011). Her addition to the bill can be seen in italics in Figure 1 below, which is the full text of the bill’s first description of regulations:

**B. Such regulations:**

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to assure the environmental protection and the life safety of its patients, and employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; and (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence; and (v) *policies related to infection prevention, disaster preparedness, and facility security of hospitals, nursing homes, and certified nursing facilities. For purposes of this paragraph, facilities in which 5 or more first trimester abortions per month are performed shall be classified as a category of "hospital";*

*Figure 1.* The first stipulation of regulations listed in VA Senate Bill 924. Adapted from “SB 924 Hospitals, nursing homes, etc.; regulations required of Board of Health” by Virginia General Assembly Legislative Information System, 2011. Copyright 2011 by the Virginia General Assembly. Reprinted with permission.

As stated in Senator Byron’s amendment, SB924 has given the new classification of “hospital” to reproductive health clinics and outpatient facilities performing abortions (Hospitals, nursing homes, etc.; regulations required of Board of Health, 2011). The first type of TRAP law pertains to licensing requirements: providers of first-trimester abortions and their associated facilities must obtain a license to operate (unlike other outpatient facilities) and must have a licensed physician on-call at all times (Hospitals, nursing homes, etc.; regulations required of Board of Health, 2011). According to Greenier & Glenberg (2014), licensing requirements require time with which to achieve compliance, but also present logistical difficulties such as finding and retaining physicians to serve on-call around the clock.

Because SB924 was passed as “emergency safety legislation,” clinics were given a two-year grace period to make the necessary changes (PPFA Interview - VA Beach, 2013). Facilities unable to meet compliance standards would be forced to close their doors following a Department of Health safety inspection (PPFA Interview - VA Beach,

2013). However, the licensing requirement is just one obstacle presented by the TRAP regulations.

The second type of TRAP regulation pertains to architectural requirements. These requirements are not detailed in the text of the bill. However, because abortion care facilities are classified as hospitals under TRAP, they become subject to Department of Health building codes that are the same as those of inpatient or surgical facilities (Hospitals, nursing homes, etc.; regulations required of Board of Health, 2011). These requirements include mandates such as the minimal number of doorways, parking spaces, and janitors' closets needed on the premises, as well as having water fountains in waiting rooms and hallways of a certain width (Gold & Nash, 2013). Though large organizations like Planned Parenthood had already begun to implement changes like this in their construction of new facilities, smaller, privately owned clinics face considerable financial burdens in attempting to make the needed changes within the prescribed time (PPFA Interview - VA Beach, 2013).

Initially, the Virginia Board of Health offered a clause that would provide exceptions for (i.e., "grandfather in") existing clinics (Greenier & Glenberg, 2014). In this case, the bill's construction regulations would not apply to clinics built before the bill's adoption (Greenier & Glenberg, 2014). The Board of Health voted seven to four in favor of this amendment, but Attorney General Ken Cuccinelli declined to certify the change (NARAL Pro-Choice America, 2012). The Attorney General asserted that the Board of Health had "overstepped their authority" in offering the amendment, and sent SB924 back to the Board for a second round of review (Portnoy, 2014).

The Board of Health rescinded the proposal, voting 13-2 against the proposal to except existing clinics (NARAL Pro-Choice America, 2012). This meant that all abortion providers in Virginia – numbering between fifteen and twenty at the time – would need to make structural changes to their facilities in order to comply with the new law (NARAL Pro-Choice America, 2012). This set the stage for subsequent backlash by abortion rights activists, as SB924 was originally intended for only new construction, and only to the previously described inpatient facilities (e.g., hospitals) (NARAL Pro-Choice America, 2012).

### **Implications**

In understanding the history and various requirements of Senate Bill 924, it is important to note that Virginia’s version of TRAP is not the only one in the United States. As seen in Table 1 below, Virginia is one of twenty-eight states that have implemented these laws. Though each state is unique in its choice of requirements, TRAP requirements in all states will ultimately limit access to abortion.



# Targeted Regulation of Abortion Providers

STATE	REGULATIONS APPLY TO SITES WHERE:*			FACILITY REQUIREMENTS:					CLINICIAN REQUIREMENTS:		
	Surgical Abortion Is Provided		Medication Abortion Is Provided	Structural Standards Equivalent to Those for Surgical Centers	Procedure Room Size Specified	Corridor Width Specified	Maximum Distance to Hospital Specified	Transfer Agreement with Hospital	Requires:		OB/GYN Certification or Eligibility
	Outpatient Clinics	Private Doctor Offices							Hospital Privileges	Hospital Privileges or Alternative Agreement	
Alabama	X	X	X	X		X			§	X	
Arizona	X	X	X	X			30 miles <sup>0</sup>			X	
Arkansas	X	X	X	X	X		30 miles				
Connecticut	X			X							
Florida	X		X	X						X	
Illinois	X	X		X	X	X	15 miles			X	
Indiana	X		§		X	X	adjacent county			X	
Kansas	§	§	§	§			§		§		
Kentucky	X		X	X				X			
Louisiana	X	X		X	X		§		§	X	
Maryland	X			X							
Michigan	X*		X	X	X	X	30 minutes	X			
Mississippi	X	X	X	X	X	X	30 minutes		§	X	X
Missouri	X*			X		X	15 minutes		X		
Nebraska	X	X	X	X	X			X			
North Carolina	X		X	X*		X					
North Dakota							30 miles		X		
Ohio	X			X				X			
Oklahoma	X		X	X	X		§		§	X	
Pennsylvania	X	X		X	X	X		X			
Rhode Island	X	X	X	X							
South Carolina	X	X	X	X		X				X	†
South Dakota	X	X	X	X		X					
Tennessee							adjacent county		X		
Texas	§	§	§	§	§	§	30 miles	§	X		
Utah	X	X	X	X	X		15 minutes		X		
Virginia	X	X	X	X	X	X		X			
Wisconsin	X		X					X	§		
TOTAL	24	13	16	22	11	11	11	7	5	9	1

§ This law is temporarily enjoined pending a final decision in the courts.

\* In most states, regulations apply to all abortion providers or apply to providers who perform or administer more than a small number of abortions. In Michigan and Missouri, requirements apply only to sites where abortion is the primary service.

† Only an obstetrician/gynecologist may provide abortions after 14 weeks of pregnancy.

0 Applies only to surgical abortions.

*Table 1. Targeted Regulations of Abortion Providers Applied to 28 States*

*Note.* Values are as of 2013; only for continental United States. Reprinted from “State Policies in Brief: Targeted Regulations of Abortion Providers” by Guttmacher Institute, 2015. Copyright Guttmacher Institute, 2015. Reprinted with permission.

Table 1 demonstrates how extensive TRAP requirements may be, which suggests that a wide variety of services may be impacted by these regulations. However, it is important to draw attention to what has been the ultimate result of TRAP’s implementation: the gradual shuttering of reproductive health clinics which cannot afford to remain in compliance with the bill’s terms.

Those backing the bill may also argue that, as safety legislation, TRAP is holding outpatient healthcare to a higher standard of excellence. While demanding oftentimes-costly renovations, the bill ensures that facilities are up to code with the most recent building regulations for larger healthcare institutes. This could potentially instill a sense of security in those seeking services there. Additionally, by mandating a transfer agreement with hospitals, and that the physician on-call have admitting privileges in case of emergency, the care that women receive could be enhanced (see Table 1, above).

The true extent of TRAP's implications cannot be determined through mere speculation, analysis of statistics, or even through interviews. It has been several years since the bill's passage, and it remains in effect; however, as the landscape of abortion access changes in Virginia, so too does TRAP's role.

## **Responses**

Throughout the rest of this paper, and especially in the Interviews and Analysis chapter, I will draw from interview data with relevant individuals. In order to reference these interviews, I will refer to the individual interviewed by the role that they play in the ongoing discussion about abortion, and assign them a code (e.g. Participant X).

Much of the reaction to the passage of TRAP has come from those who argue that the bill was passed only to restrict abortion access, and not to ensure greater safety for women obtaining abortions, as its creators suggested. According to one pro-choice grassroots representative (Participant G), pro-choice representatives contended that the TRAP laws were nothing more than a strategic power play on the part of GOP legislators (Participant G, 2013). Opponents of the bill note that it is also easier for a legislator to pass legislation than it is to appeal or reverse enacted laws. This is partially evidenced by

the fact that Virginia's TRAP laws were introduced to the state Congress in 2011, but were not implemented fully until Governor McDonnell's term was nearly completed (Participant G, 2013).

Additionally, some on the pro-choice side of the argument maintain that the bill should not have been passed as emergency safety legislation (Participant G, 2013). The label of "emergency" historically has implied that the state or nation is in a declared state of emergency, in which harm to citizens is considered imminent. The Virginia Department of Emergency Management states that, in such a state of emergency, "a Governor's declaration [of a state of emergency] allows state agencies to bypass some time-consuming paperwork and procedures in the interest of quickly getting assistance to local governments, and in turn to residents of the Commonwealth" (Virginia Department of Emergency Management, 2012).

Treating the provisions of SB924 as emergency legislation – akin to that passed in the cases of natural disaster or threats of terrorism – suggests that abortions are inherently life-threatening, or at the very least quite dangerous for the women involved. Those who favor abortion rights cite current statistics that reveal that less than 0.3% of women who undergo an abortion experience complications requiring hospitalization, and approximately four in one million women die from legal abortions (Gold & Nash, 2013). While the procedure has been proven to be safe for the women who undergo it, it is, of course, lethal to the fetus if performed correctly. This is an important grounding principle to understand when assessing the reasoning of those who proposed and created the bill.

Additionally, the language used by pro-choice and pro-life advocacy groups has played an integral role in framing the issue in the eyes of the general public. Legislative

terminology often, and sometimes intentionally, is filled with jargon that is beyond the comprehension of many American consumers. Beyond that, the intentions a legislator originally has for a proposed bill often shift, so much so that the original meaning is lost, or new terms are added to the bill that change its impact.

The following illustrates this point. Despite apparent consensus among members of the General Assembly regarding TRAP, the passage of the bill produced at least some collateral fall-out. Shortly after the enactment of SB924, Virginia Commissioner of Health Karen Remley (a physician) abruptly resigned from her position (Vozzella, 2012). In her letter of resignation, she wrote that “Unfortunately, how sections of the Virginia code... have been and continue to be interpreted has created an environment in which my ability to fulfill my duties is compromised and in good faith I can no longer serve in my role” (Vozzella, 2012). Commissioner Remley went on to explain that her decision to step down was a result of the requirements of SB924, and the subsequent impact they would have on women’s healthcare access in Virginia (Vozzella, 2012).

Indeed, several healthcare professionals and policymakers had come forward to point out the medical and even legal inaccuracies of the reasoning in support of TRAP. In October 2011, a year prior to Commissioner Remley’s resignation, representatives of the American Congress of Obstetrics and Gynecology wrote an open letter to Commissioner Remley. In this letter, they described TRAP laws as “onerous and unnecessary,” a phrase that has become one of the slogans of the pro-choice’s fight against the bill. (Puritz, Bendheim, & Chisholm, 2011). The letter was written in the midst of TRAP’s path to adoption, and included five comments on the bill’s subsections, meant to provide medical accuracy to the bill (Puritz, Bendheim, & Chisholm, 2011).

Conversely, those who support the bill saw TRAP as a necessary piece of legislation that represented the interests of conservative Virginians (Virginia Catholic Conference, 2013). For example, Jeff Caruso, the executive director of the Virginia Catholic Conference, described TRAP as a “commonsense, long overdue measure” that would “prevent policies that favor the abortion industry” (Terrini, 2011). Some of those who support the legislation are unaware of the objections of medical professionals and officials. These supporters are wont to accept the law at face value and see it as correct and morally just. The general public may find it necessary to wade through complicated issues that are made more obscure by political rhetoric.

### **Related Factors at Play**

It is important to note that there has been a steady decline in the number of abortion providers in Virginia, as well as across the nation, since the early 1980s. This trend can be seen in Figure 2 below.

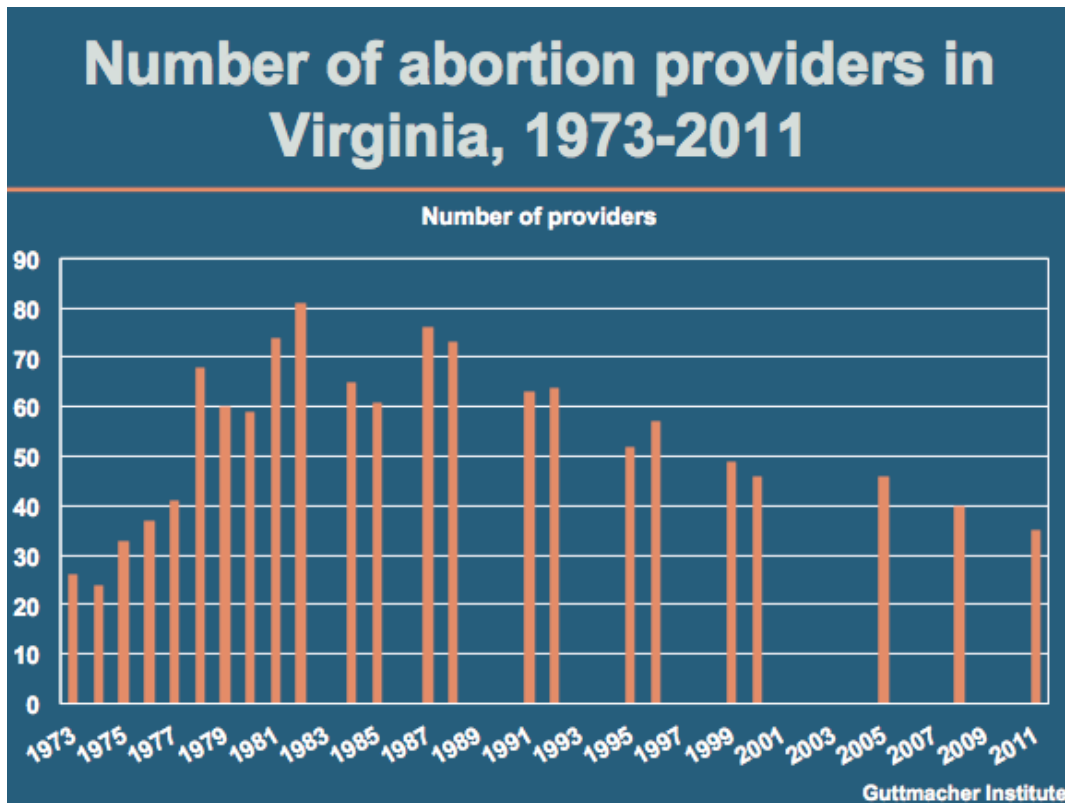


Figure 2. Trend in Number of Abortion Providers in Virginia from 1973-2011. Adapted from “Trends in Abortion in Virginia, 1973-2011” by Guttmacher Institute, 2014. Copyright 2014 by Guttmacher Institute. Reprinted with permission.

The downward slope of the graph in Figure 2 suggests that clinics providing abortions have been closing their doors since well before the passage of TRAP. So what explains this state and nationwide trend?

Legislation with effects similar to TRAP has been proposed and passed since *Roe v. Wade* was decided in 1973. Those working in opposition to the ruling sought to overturn the “core” constitutional mandate of *Roe* by attacking “edge” issues like public funding for abortions, informed consent laws, and parental involvement in the case of pregnant minors (Garrow, 1998). As it became increasingly difficult for a woman to obtain an abortion – except, perhaps, for insured, high-income women living in close

proximity to a clinic – the supply and demand relationship for legal abortion became skewed (Boonstra, 2007). This trend has persisted into present day.

In addition to these barriers to access, threats of attacks on abortion providers began to surface in the decades following the *Roe* decision. These threats at times resulted in actual violence, such as in the highly publicized murder of Dr. George Tiller in 2009 (Stumpe & Davey, 2009). As abortion care became dangerous for providers, and legislation became increasingly restrictive, keeping a clinic open became less feasible on many levels. On the consumer's side, distance from the dwindling number of facilities providing abortions created physical barriers to access (Donohoe, 2005). Financial limitations affected a large number of women seeking abortions, many of whom had incomes below the established federal poverty level (Donohoe, 2005). Given that a first-trimester abortion costs approximately \$480 (Guttmacher Institute, 2014), the costs were often prohibitive to many women seeking the service.

This chapter has focused on the history and implications of Senate Bill 924, as well as the related factors influencing reproductive healthcare access in Virginia. There is still much to be learned about the dynamics of policymaking and the mobilization of the public, but understanding the impact of the bills shaping our rights is a necessary first step. However, no legislation exists in isolation; indeed, TRAP will work in tandem with the laws governing our healthcare system at large, producing an effect on healthcare access unique to Virginia. To illustrate this, I will now turn to the interplay that exists between TRAP and a second powerful, yet controversial bill – the PPACA.

## **Chapter 3: PPACA and Hospitals**

### **PPACA and Virginia's Hospitals**

The Patient Protection and Affordable Care Act (PPACA) was signed into law in March of 2010 by President Obama as a comprehensive healthcare reform package, aimed at making insurance more affordable and coverage more inclusive (Main & Starry, 2010). It is comprehensive in that it addresses many facets of healthcare and has been enacted nationwide. Proponents of the bill assert that it will allow states to maintain their autonomy and Constitutional rights, while many opponents feel that it will only add to our bloated bureaucracy's control of individual liberties. Regardless, the bill's various terms and mandates will surely impact healthcare access in the coming years, both positively and negatively.

Upon passage of the bill, many of its measures went into effect immediately, while others were implemented as recently as 2014. One such effect is the full federal financing provided to individuals who are newly eligible for Medicaid under PPACA, meaning that those whose annual incomes are up to 133% of the Federal Poverty Level will now be insured (Main & Starry, 2010). While this could potentially be a great advantage to some of the poorest people in Virginia, it presents a unique challenge for the state's hospital systems. Currently, up to 75% of hospital visits not resulting in admission are classified as "non-emergency," and by law, should be treated in outpatient care facilities (Hwang, Liao, Griffin, & Foley, 2012).

Compounding this problem, the number of emergency departments (EDs) nationwide has been decreasing steadily over the last thirty years, due to irreconcilable financial losses (Hwang, Liao, Griffin, & Foley, 2012). Unfortunately, the negative



correlation that exists between the number of EDs and the demand for their services leads to longer wait times for emergencies, physician burnout, and decreased exam times (Hwang, Liao, Griffin, & Foley, 2012). With this relationship already in place before PPACA's implementation, the projections become increasingly grim when taking into account the expanded coverage that PPACA promises.

While some argue that increasing Medicaid coverage to the uninsured would reduce unnecessary ED visits, research has found that, prior to PPACA, the most frequent visitors of EDs were Medicaid recipients with established primary care providers (PCPs) (Hwang, Liao, Griffin, & Foley, 2012). Uninsured individuals must pay out of pocket with our fee-for-service healthcare model, but new Medicaid recipients are found to be more likely to use (and abuse) EDs. This is a result of both their newly insured status and the potential difficulty that may arise in finding a PCP due to the sizeable influx of other newly insured patients (Hwang, Liao, Griffin, & Foley, 2012).

The network of ambulatory care, free, and reproductive health clinics play an integral role in the safety-net system that has become the foundation of Virginia's larger healthcare system. Primary care provided by clinics is more cost-effective than the equivalent services provided in a hospital setting, which will prove to be important as Virginia's economy shifts under PPACA (Hwang, Liao, Griffin, & Foley, 2012). Current data attribute upwards of \$38 billion in wasteful spending each year to ED overuse, which is a particular burden for a country recovering from an economic recession (Sternberg, 2011). Not only does this underscore the importance of keeping clinics accessible and in operation, but suggests that there is a disconnect between our healthcare

system and the general public. Until we become better educated on how to appropriately utilize hospitals, clinics, and private practices, the system will continue to be abused.

One of the potential benefits of correcting the poor distribution of services is better access to primary care by a great proportion of the population. Clinic-based primary care serves to reduce the number of unnecessary ED visits by establishing preventive care routines for patients, which minimizes the amount of late-stage treatment needed (Sternberg, 2011). Additionally, due to the high prevalence of chronic disease within low-income populations, easy access to preventive and non-emergency care is critical for maintaining the overall health of the public and keeping chronic care checkups out of emergency rooms.

While the relationship between hospital overuse and clinics providing abortion care may not be obvious, it is important to note that many clients who frequent reproductive health clinics treat them as primary care facilities. Annual reports list the services technically offered by these clinics, but do not speak to the work clinics must do in making referrals upon detection of certain diseases, or the various forms of counseling offered. Hospitals are neither equipped nor staffed to handle routine care, and more EDs are at risk of shutting down due to the aforementioned “financial losses” if current trends continue (Hwang, Liao, Griffin, & Foley, 2012). A recent study found that roughly 40% of patients who visit EDs would be willing to be referred to a clinic or PCP (Grumbach, Keane, & Bindman, 1993). If providers are looking to redirect services out of EDs, and patients are happy to comply, this suggests that there is potential for a highly cooperative dynamic between clinics and hospitals under PPACA.

Beyond Medicaid expansion and its effects, there are two other measures of PPACA that further complicate Virginia's disequilibrium in primary care supply and demand. The first is that, as of 2013, Medicaid reimbursement was increased to 100% of Medicare rates to shift more of the focus to primary care (Main & Starry, 2010). While this initially seems advantageous, it should be noted that with more Americans covered by Medicaid under PPACA, there is likely to be an increase in those seeking care from clinics. If there are fewer Medicaid-receiving clinics open due to TRAP, the disequilibrium will likely worsen.

Secondly, due to Medicaid expansion and the individual mandate, PPACA has begun to dramatically reduce federal payments to DSHs, or "disproportionate share hospitals" (Main & Starry, 2010). These are facilities that serve a "significantly disproportionate number of low-income patients" and receive Medicaid and Medicare payments to cover the costs of providing care to uninsured individuals (Health Resources and Services Administration, 2015). However, with the projected drop in the number of uninsured Americans, PPACA reduced these payments by 75% in 2014, and will only increase payments depending on how much of the population remains uninsured and how much uncompensated care is still being provided to them (Main & Starry, 2010).

Virginia serves as a challenging case study in the scale-up of comprehensive healthcare, and residents may suffer more at the hands of PPACA than residents of other, more compliant states. Virginia policymakers decided against expanding Medicaid when PPACA was first introduced, and currently maintains that status (U.S. Centers for Medicare & Medicaid Services, 2015). This implies that, while DSH payments are cut

and full federal financing is extended to Medicaid-eligible recipients elsewhere, both Virginia residents and hospitals will be disadvantaged financially.

### **PPACA and Abortion Access**

Beyond Virginia's specific stipulations about hosting insurance plans that cover abortion services within the state exchange, PPACA has remained steadfastly neutral in regards to the issue of abortion. Except in the case of employers with religious opposition, all PPACA insurance packages cover routine contraceptive care; however, no plan is required to cover abortion services or abortifacient drugs (those which induce abortion) (U.S. Centers for Medicare & Medicaid Services, 2015). In theory, it is sufficient to provide barrier and hormonal methods of contraception, as these have been proven to reduce the unwanted pregnancies that lead women to seek abortions.

Unfortunately, due to inequity in education access, proximity to providers, and other social determinants, not having access to first trimester abortion services will have its own consequences. In the words of one of Virginia's abortion care providers: "making abortion illegal does not stop abortion; it just makes it illegal" (Richmond Medical Center for Women, Richmond Medical Center for Women Interview I, 2013). Forcing the service underground has dangerous repercussions, as women historically have been shown to take matters into their own hands, and seek provision of the service by any means possible.

This threat is especially relevant in the case of low-income women seeking abortion services. Prior to the passage of PPACA, federal funding restrictions on Medicaid were found to be correlated to an increase in indigent women carrying unwanted pregnancies to term, due to the inability to afford an abortion (Henshaw, 1995).

One study found that up to 35% of these low-income women followed through with unwanted pregnancies, ultimately resulting in a lower national abortion rate, while potentially diminishing the quality of life for many below the federal poverty line (Henshaw, 1995). Now that Medicaid has been expanded, but abortion services remain restricted, it is unclear what trends will develop in both the number of unwanted pregnancies and the abortion rate. Virginia's complex relationship with PPACA and its terms makes it particularly difficult to assess what the future holds for those relying on Medicaid for healthcare, as well as for women seeking reproductive care generally.

### **PPACA and Virginia**

Abortion access also has played a unique role in Virginia's establishment of a health benefits exchange, which is one of PPACA's primary mandates, but against which the state originally filed suit (Jamerson, 2012). Each state is required to either establish its own marketplace through which individuals may purchase state-specific insurance packages, or allow the federal government to facilitate such a marketplace on their behalf (The Henry J. Kaiser Family Foundation, 2015). Former Attorney General Ken Cuccinelli originally claimed that this mandate violated Virginia's state rights, but in a surprising turn of events, House Bill 2434 was introduced in 2010, and passed by a considerable majority by both chambers of Virginia's 2010 General Assembly (Jamerson, 2012). This bill detailed Virginia's goal to establish a state exchange in cooperation with PPACA, and moved quickly on to Governor Bob McDonnell for endorsement (Health benefits exchange; intent to develop, 2011)

Governor McDonnell, who would later sign the TRAP laws into effect in 2011, made several key amendments to HB 2434, most of which had to do with reaffirming

Virginia's stance on abortion. The specific text of his most significant recommendation is as follows: "The Virginia Exchange shall ensure that no qualified health insurance plan sold or offered for sale through an exchange provides coverage for abortions, except for an abortion performed when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or when the pregnancy is the result of an alleged act of rape or incest" (Jamerson, 2012). The Governor's recommendations quickly passed through the Republican House of Delegates, and won by a narrower majority in the Senate, even amid questions of their relevance (Jamerson, 2012).

Virginia continues to assert its state rights, often in conflict with the mandates of PPACA; for example, the state opted not to expand Medicaid until this year, and ultimately failed to establish a state-run marketplace (The Henry J. Kaiser Family Foundation, 2015). Gubernatorial influence on our legislation should not be underestimated; indeed, the governor has the final say when it comes to the laws by which we live. 2014 marked the end of Governor McDonnell's time in office, but his impact on state legislation remains, both in terms of PPACA implementation and the continued enforcement of TRAP.

Though current Governor Terry McAuliffe represents the Democratic Party and is regarded as more liberal than Governor McDonnell, it is far more difficult to undo the legislative achievements of a predecessor than to put new laws on the books. In regards to both PPACA and TRAP laws, Governor McAuliffe would have to be strongly committed to reversing decisions made during Governor McDonnell's tenure, and even then, may never see those reversals during his time in office. However, it should be noted that at the

time of this writing, Governor McAuliffe has already taken preliminary steps in doing just this. In May of 2014, the governor appointed well-known abortion rights advocates to the Board of Health, charging them with reviewing the terms of TRAP (Vozzella, 2014). This is a promising development, and suggests an area for further investigation as time goes on.

Ongoing issues like abortion access often are forced out of the spotlight on political agendas due to focusing events, like the September 11<sup>th</sup> attacks or the economic recession of 2009 (Birkland, 1998). In the case of PPACA, which technically encompasses abortion access, national attention was focused with laser-like intensity on the politics driving the bill, what the implications were for our future, and what it meant for us as individuals. It was only after the broad terms of the bill were digested that focus was again directed toward abortion.

If Virginia's struggles with the adoption of PPACA are any indication of how headstrong our voters and interest groups are, it is unlikely that either side of the state's abortion debate will ever find compromise that is satisfactory to all. These challenges are best personified by the accounts of those involved in the debate over abortion access. The following chapter will analyze the input of these individuals, and hopefully inject a degree of humanity into this political tug-of-war.

## Chapter 4: Interviews and Analysis

### Overview

The initial research objectives guiding this project were simple: I sought to learn about TRAP laws, the legislation passed leading up to their conception, and who the relevant actors were in the debates surrounding TRAP. To do this, I accessed literature on Supreme Court cases framing the issue, from the 1973 *Roe v. Wade* decision to the present, and generated a timeline to map them alongside other important world affairs. I also read pertinent chapters of our state jurisprudence to understand what is currently “on the books” about abortion. However, there was a key piece missing from my understanding of abortion access and the legislation surrounding it – I had no personal narratives that could bring to life the factual and historical accounts of the changing laws.

To address this discrepancy, I decided to identify and interview individuals who occupied roles closely associated with the debates on and passage of the legislation at hand. I chose professionals in policy-making, advocacy, and abortion care roles. I then identified three types of stakeholders that seemed central to the discussion: physicians, members of public interest groups, and politicians. I drafted an interview schedule that I intended to use with all respondents, but in the interview sessions, I discovered that I could glean the most from asking more situated, personal, and particularistic questions. As I was not trained in social science interviewing, nor had I been advised by a trained researcher, I made the decision to personalize all interview questions for each individual interview.

My initial experiences revealed how green I was to this process. Not only was I new to the mechanics of arranging and executing interviews with those experienced in



different fields, but my questions varied widely across interviews and resulted in “data” that proved difficult to analyze and even harder to interpret. Additionally, though I was aware before beginning this process that my questions did not address a singular research objective, I hoped to find direction to my research through the responses of my participants. I contacted Planned Parenthood administrators, clinicians, and multiple advocacy groups, and thus began my first foray into social science fieldwork.

### **Themes**

In the following pages, I attempt to extract broad patterns and themes from the diverse questions I posed during my initial round of interviews. In total, I interviewed: three physicians, three Planned Parenthood representatives, two public interest groups, one crisis pregnancy center director, and an independent grassroots organizer. I was unable to reach legislators, as I had hoped to, so the voices of policymakers are not included in the discussion born from this round of interviews. Despite the inherent value of each interview I conducted, this chapter will not pull from every one of them, but instead frame the key insights using pertinent excerpts.

To outline the patterns and themes detected in the interviews, I will examine each one by one, beginning with the impact of roles. Despite the inconsistencies in the questions I asked and the manner in which I asked them, I did observe consistencies that concerned the specific roles of the interviewees as professionals. Respondents appeared to understand the legislation and the processes surrounding its passage from the perspective of these roles. For example, one of the physicians I spoke with had served as a plaintiff in several landmark court cases on reproductive healthcare. He was able to articulate why he supported unhindered abortion access as a practitioner, but could also

elucidate his views in a different way from his experiences as a plaintiff. Similarly, advocacy group representatives understood the issue through the lens of PAC involvement and lobbying, but could not always refer to the medical evidence backing or refuting their views.

A second, and closely related, theme concerns the role of “information” and its use in framing events and understandings. Specifically, those occupying different roles referred to “pseudo-scientific,” factually inaccurate, and un-evidenced events as central themes in describing and explaining their viewpoints. This manifested itself on both sides of the political aisle, from both “pro-life” and “pro-choice” individuals, and revealed fundamental flaws in the way in which we discuss abortion. To serve as an example, the following is a quote from the owner and director of a crisis pregnancy center – a nonprofit organization that provides free counsel and services to women with unplanned pregnancies (Gilbert, 2012). She will henceforth be referred to as Participant A. When asked about what her crisis pregnancy center could offer a woman seeking their services, Participant A proffered the following:

“I’ve heard stories, but haven’t verified them myself, but stories where women will go into abortion centers and the [pregnancy] test will even be negative, but they’ll say, ‘Oh well you could be pregnant, so let’s give you this [abortifacient drug] anyway, let’s make sure you’re not.’ And now they have the morning-after pills and stuff like that, and there are lots of risks to that, too.” (Participant A, 2013)

Though she was speaking in an informal setting, and prefaced her statement by admitting to a lack of verification, the “stories” Participant A references have clearly influenced her perspective on “abortion centers” and their services. In her role as a professional who advises women in “crisis” pregnancies about their options, this type of biased thinking can impact professionalism and objectivity in sensitive situations. For the

sake of clarity and correctness, it should be noted that no literature or research exists that validates the claims that an abortion clinic has ever acted in the manner described by Participant A. The FDA also currently deems the “morning-after pill” fit for over-the-counter use, which suggests that its potential side effects do not merit stricter regulation.

However, Participant A was not the only interviewee who referenced misinformation or hearsay as fact or part of their opinion. While interviewing a Planned Parenthood representative (hereafter called Participant B) about their opinion of the direction that Virginia’s legislation was headed in, the following statement was made:

“A lot of people don’t realize how close their rights are to being taken away. Not just with abortion, but birth control, too. Across the states, there are bans earlier and earlier, making women go through completely unnecessary procedures, listening to this or that prior to having a procedure.” (Participant B, 2013)

Both Participants A and B exhibited similar willingness to discuss information in the abstract. This suggests that, within social justice issues, a dichotomous relationship between thoughtfully crafted, public statements and private, more casual treatments of certain topics exists. Though Participant B was also speaking in the conversational manner many of us employ to discuss relevant, but poorly defined, information, this approach calls credibility into question.

In addition, the Planned Parenthood representative (Participant B’s) response speaks not so much in falsities or pseudo-scientific terms as it does in vague generalizations that could be misleading for the average American. While there have been recent laws passed regarding the use of trans-vaginal ultrasounds and certain informed consent measures (the “unnecessary procedures” and “listening to this or that” referenced by Participant B), these are by no means entirely new regulations. In speaking

with a veteran abortion provider (Participant C) about the effects of TRAP and other recent, statewide legislation, the following point was made:

“There isn’t a part of TRAP that is in the interest of women’s health. Not a single piece. Most of the abortion clinics, nearly all the abortion clinics, were already doing ultrasounds on their patients. I did trans-vaginal ultrasounds in Sana’a, in North Yemen, in 1999. People...if they think you’re working in their best interest, then they don’t have problems with stuff like that. And then it became a political football, and it just happened to land on our side.” (Participant C, 2015)

While it may benefit an activist group or political party to focus on certain provisions, amendments, and stipulations of certain laws, it is important to note that many of these build upon standard practices already in place. Observing this frequency in the use of misinformation or rumor led me to question the soundness of the general public’s understanding of the topic; after all, if experts in the abortion debate had incomplete understandings of the topic, how could the average consumer be expected to know more?

In the second round of interviews, completed this year (2015), I sought to explore ignorance of the law as it pertained to advocates, physicians, policymakers, and the general public. To gauge this, I asked individuals the following questions:

<p>Do those who oppose abortion ever access information on opposing points of view, and if so, with what frequency?</p> <p>Do those who support abortion ever access information on opposing points of view, and if so, with what frequency?</p> <p>Do those who oppose abortion access read research literature on abortion and the characteristics and experiences of those who use the service?</p> <p>To what extent is the general public knowledgeable about abortion and abortion-related legislation?</p> <p>What types of information are most readily available?</p>
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In my second interview with Participant C, he and his assistant both expressed concern that the general public has adequate access to information, but lacks discretion in analyzing what they are told (Richmond Medical Center for Women, 2015). When

discussing how knowledgeable the general public is about abortion and related legislation, Participant C's assistant noted that:

“Way back, before things were as bad as they are now, elections would be coming up, and you'd try to get patients fired up about it... But patients aren't political. And they are here to get their abortion, but they don't really think about [legislation] too much I don't think.” (Richmond Medical Center for Women, 2015)

Participant C and his assistant noted, in a similar vein, that neither pro-choice nor pro-life advocates are wont to access information on opposing points of view (Richmond Medical Center for Women, 2015). This is reflective of the aforementioned disconnect between our healthcare system and the general public: the public is not only failed by the system's lack of adequate outreach, but fails itself by not actively seeking education.

The third recurring theme among the first pool of interviews was making reference to religion when discussing abortion, medicine, or the law. This was seen more prominently in interviews with individuals who identified as “pro-life,” many of whom associate their pro-life stance with the predominant views of their religion on the matter. However, it is worth noting that several “pro-choice” interviewees, including abortion providers themselves, also acknowledged that their religious background influenced their opinions on the matter and the work that they did.

Though many Americans affiliate with an organized religion, the implications for religiously-driven thought at the workplace are far-reaching. The U.S. was founded on the principle of religious freedom for all, so while it is acceptable to exercise that liberty in a professional setting, the boundaries become hazy when patient interaction is involved. The question arises: at what point are you imposing your own beliefs on those who come to you to seek your services?

Participant A, the director of the crisis pregnancy center, again serves as a prime example to highlight potential repercussions of bringing religion into the abortion discussion. Below is a quote from the same interview, when Participant A was asked what kind of information a woman seeking abortion services would receive at her center:

“So I say, are you Catholic, Christian, Muslim, Buddhist, Atheist... But really abortion is against any religion; it’s against the Muslim religion, against the Jewish faith. So we talk about that. Even the Atheists...because people will come in and say, no I don’t believe in God. Okay, the man gives the sperm, the woman gives the egg, where does that life force come from then?” (Participant A, 2013)

This interview excerpt not only makes generalizations about many major religions, but is another example of broad assertions being made with little to no backing evidence. Additionally, religion appears to tinge the discussion of abortion in this instance, excluding those who do not subscribe to a certain religion from the moral discussion at hand.

However, right and wrong as dictated by a religion’s holy texts or figureheads could indeed diverge from one’s own moral compass. Religious teachings can also be interpreted in different ways, such that abortion can be either religiously valid or invalid depending on the individual. In speaking with Participant C on the matter of his religious views on abortion, and religious affiliations at large, the following interpretation was described:

“I think my religious view has to do with, and is what always guides me, is that the second commandment was ‘taking care of your neighbor.’ And that’s where I’m from almost always.” (Richmond Medical Center for Women, 2015)

While both Participants A and C were able to articulate their view of religion’s impact on their work, neither spoke to the possible dangers of using religious doctrine to guide beliefs in the workplace. It was indeed the subjectivity of faith that, led, in part, to

the development and implementation of professional and legal codes, which still govern many workplace interactions (Brandl & Maguire, 2002). More than one physician interviewed – as well as public interest group representatives and attorneys – was quick to acknowledge that abortion is, fundamentally, an outpatient medical procedure. While there are deeper considerations concerning women’s civil rights and the sanctity of potential human life, the woman’s safety has not been an issue (Guttmacher Institute, 2013). Treating abortion as an exception for religious reasons challenges both the ethics and the constitutionality of our laws, and suggests that as a society, we would favor subjective religious convictions to the proven evidence of medical safety.

In order to investigate this further, I developed questions for the second round of interviewing that focused on the impact of religion on policymaking, voting trends, and the general public’s perception of the matter. These questions have been recreated below:

<p>If any, what are your religious views on abortion? If any, what are your religious views on the regulation of abortion access? Do you believe religious beliefs affect Virginia’s policy-making on abortion? Should religious views affect state and federal laws? If so, how, and to what extent? Have your religious beliefs shaped your view about abortion issues? Do religious beliefs affect the implementation of TRAP regulations? If so, how?</p>
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The time that had elapsed since the first and second interviews with Participant C allowed for valuable points of comparison. Participant C noted the trickle-down effect in our legislature, and how it brings with it religious leanings. In response to the question of whether or not religious beliefs affect Virginia policymaking, Participant C and his assistant said, respectively:

“We got all these guys elected from Bush on down. It’s a mess we’ve got ourselves in now, because we elected a dumb man... McDonnell was elected by mostly religious factors. I think the Republican Party has been dominated by religion or find their strength in that area... You look at this legislative body, and the first 6 laws they introduced were anti-abortion.” – Participant C  
“Yes Cuccinelli is gone, McDonnell is gone, but McDonnell appointed people to the Board of Health. He still has influence... Even if you got rid of everybody today, all the people he appointed would still be there.” – Assistant to Participant C (Richmond Medical Center for Women, 2015)

Participant C touches on a critical issue. The party ties of the governor in office are undoubtedly important, but even when a new governor is elected, their appointees remain. This can serve as a confounding factor in either advancing or reversing certain pieces of legislation. Incongruence of beliefs between said Board of Health members and the newly-elected Governor McAuliffe has the potential to stall legislative progress even more. In a country grappling with a “do-nothing Congress,” stagnancy on a state-level seems lethal.

The next focal point of my interviews centers on the creation of abortion-related legislation and regulations. The many voices of the dialogue surrounding abortion access can impact different components of the policymaking process: public interest groups can influence voters, physicians can inform patients of their rights, and legislators can mold the legislation that directs these relationships. However, each actor in this process is involved in varying degrees, and comes in contact with other actors under many varied circumstances. I sought to understand how each individual I spoke with had been involved with reproductive healthcare legislation, and how one’s expertise can enhance or detract from their work in furthering or fighting certain policies.

When speaking with physicians – all of who ran or were affiliated with clinics outside of a hospital setting – it became clear that their profession lent itself to two



primary forms of legislative involvement. The first was endorsement of candidates (e.g. Planned Parenthood's public support of certain pro-choice contenders), and the second was direct involvement with or advocacy regarding certain laws. The latter manifested itself in the form of court case involvement, as well as membership in organizations like the American Civil Liberties Union (ACLU) or Religious Coalition for Abortion Rights (RCAR) (Richmond Medical Center for Women, 2015). Below is an excerpt from my first interview with Participant C, who has served as a plaintiff in numerous cases pertaining to abortion access in Virginia. This quotation is regarding his experience serving as both an activist and a physician:

“You do make a decision early on whether you're really going to do OB. I had successfully done OB for so many years, out in the community. But you get these people saying ‘[Participant C] does abortions, we can't go to him for our deliveries.’ So you do get that. But you get some other people who are reasonable too. And that's a whole different story, my practice and how I've addressed that. What I find interesting and offending is that you try to defend it the best that you can, medically. And the other side gets these people that defend it medically and they lie a little bit.” (Participant C, 2015)

While Participant C has had a successful career, and been involved in legislative efforts throughout, it is clear that his involvement with abortion-focused legislation has had an impact on his professional life. In speaking with advocacy groups, it became apparent that utilizing physicians as expert representatives is critical to adding credibility to an argument in court. However, it is an important factor to consider that this involvement can also have considerable repercussions on those physicians' professional and personal lives.

Organizations like the Virginia Catholic Conference, NARAL Pro-Choice America, and the aforementioned crisis pregnancy centers endorse candidates as well. This is largely based on the candidate's identification as “pro-choice” or “pro-life,” and

not based on what political party they are affiliated with (Participant A, 2013). While this distinction suggests that one could parse the focused issue of abortion access separately from the politics surrounding it, it begs the question of whether or not the public would view the two topics as distinct.

Endorsing candidates affirms an organization's view on the matter and links them with the figures who will advance their interests. However, in many ways it also enhances the tense political atmosphere surrounding abortion access, especially regarding party ties. While many organizations have PACs or are political groups by nature, there is potential for a polarizing effect on voters who have party loyalty or who would rather not vote on abortion at all. In speaking with a NARAL Pro-Choice Virginia representative (Participant D) about the conservative majority that existed in both the House and the Senate at the time, it became clear that advocacy groups have to focus their energy on candidate endorsement to generate change in the legislative process:

“In our political efforts, we're obviously working to encourage people to vote pro-choice so that we can change that, particularly in this election year, we're working to educate people about how important elections are for changing that imbalance, and basically educating people about how that imbalance begins in the first place... Ultimately, we understand that the only way we'll have change in the long term is to change who the legislators are and to get more people involved in advocacy throughout the year, contacting legislators and things like that.”  
(Participant D, 2013)

My interactions with the Virginia Catholic Conference reflected this sentiment, suggesting that advocacy work is part candidate endorsement and promotion, and part education of the public. Due to the importance of this theme, I sought to extend its treatment into the second round of interviews, and learn more about the interplay between professional work and legislative advocacy. In order to address this, I posed the following questions:

Have you been involved directly in the implementation or opposition of abortion-related laws and regulations? If yes, in what ways have you been involved?  
Are you currently involved in legislative activities that pertain to abortion? If yes, please describe.  
How did you become involved?  
Have your legislative efforts resulted in identifiable outcomes? If yes, please describe.  
If yes, are you satisfied with the results?  
Were you involved in creating or opposing TRAP regulations and/or legislation? If yes, please describe.  
Have you been involved in advancing or trying to prevent the advancement of TRAP regulations? If yes, please describe.  
Are you involved in implementation efforts or attempts to roll back TRAP regulations? If yes, please describe.  
Have TRAP regulations affected you in your work?

Participant C's experiences were particularly germane to this subset of questions, given his long-standing career and considerable involvement in reproductive healthcare legislation in Virginia. In speaking about involvement in and satisfaction with laws regarding partial-birth abortions, Participant C's assistant made the following point about the subtext of certain bills:

“About partial birth, what you should know and what the public doesn't really get about that, is that by design, “anti people” pass laws that seem to be just about this practice, this partial birth practice. But then if you read the law, it sounds an awful lot like what we do for second trimester abortions. They want to pass this law that, oops, after it's passed actually outlaws something that...the public wouldn't be so horrified by. Because although they have posters of this big horrible abortion, they don't realize that medically speaking, it could apply to other situations, and tie your hands in performing good medicine. ...The law was written presumably just to be about this one procedure.” (Richmond Medical Center for Women, 2015)

This theme of frustration or having one's hands tied carried throughout the interview, and has been reflected in the accounts of other abortion providers interviewed. This line of questioning was also valuable in that it provided insight into the more emotional or personal struggles of those providing abortion services. In speaking about

the Department of Health inspections mandated under TRAP, Participant C's assistant spoke to the stress of trying to comply with somewhat subjective expectations:

“Probably the most difficult part to me is that although they have a workbook they go by...the teams may look at things differently than the previous team. And so this team comes in and they cite you on this, and you fix that. Well then 8 months later a different pair of people come, and they don't care about that, they're big on *this*. [Participant C] says, ‘Are you ready? Are we going to be okay?’ And I always say, ‘I don't know.’ Because you think you got everything right, but by God this woman's going to look under here and see something that last team didn't see. And not that you're trying to hide something, but I just mean that one person looks at things differently than another person. And now it's in black and white in this report.” (Richmond Medical Center for Women, 2015)

Participant C and his assistant also both agreed that it takes a considerable mental health toll on the staff of the clinic, as inspections are never scheduled or announced ahead of time. While one may typically think of the effects that reproductive healthcare legislation would have on the patients involved, it is clear that it impacts those providing the services as well. Participant C and his staff are only one representation of TRAP's effects on clinics, but their sentiments are a testament to how challenging it can be to adapt to increasingly strict regulations.

The final prevalent pattern among the initial round of interviews I conducted was the interviewee's inability to make projections about the future of women's healthcare, at a state and/or nationwide level. While this is not intended to question the authority or intelligence of the individuals interviewed, it does point to the ambiguity surrounding this type of legislation. Dating back to the time of the *Roe* decision, the legislative landscape has been shaped by a series of advances and reversals from both the “pro-life” and “pro-choice” camps. Many factors determine the passage of these decisions into law, and few are predictable, even to those immersed in the field of abortion access. These factors include Senate and House party majorities, presence or absence of other focusing events,

the makeup of the Supreme Court judges, and the political leanings of the general public in a given year.

When asked about the direction he or she believed Virginia’s reproductive healthcare legislation was headed in, most providers I spoke with expressed sentiments similar to that of this Planned Parenthood representative (Participant E):

“It’s hard to say. If the last election is any indication of what is going to happen this year in VA, then hopefully we’ll see things kind of loosening up and improving for women’s health and restrictions on women’s rights. Unfortunately, a lot of people tend not to show up for off-year elections, and the people that do vote tend to be older, more conservative voters. We’ve kind of already seen the attorney general’s record as attorney general, so he has qualms about enforcing that as attorney general, so we could probably expect the same from him as governor, if not more so.” (Participant E, 2013)

The future of women’s healthcare access is inherently dubious, and shaped by many unpredictable variables. However, it is through questioning what exists, making predictions about what is to come, and preparing accordingly that progress can be made. As some time has passed since the initial round of interviews, I posed the following questions to ascertain the projections that interviewees could make now, in 2015:

- Will TRAP affect women’s overall access to healthcare in the future?
- Which aspects of Virginia healthcare will be affected by TRAP, if any? In what ways?
- Which aspects of Virginia’s economy will be affected by TRAP, if any? In what ways?
- Will TRAP regulations impact hospital use in VA? If yes, in what ways?
- Will TRAP regulations increase out-of-pocket healthcare spending for VA women? If yes, in what ways?
- Will PPACA impact hospital use in VA? If yes, in what ways?
- Will PPACA make primary care more affordable for VA women? More accessible? If yes, in what ways?
- Will TRAP impact the implementation of PPACA in VA? If so, in what ways?
- What problems have emerged, or do you foresee emerging, with the implementation of PPACA in VA?

In speaking with a healthcare lawyer (Participant F) on the above questions, I was able to better understand how governing bodies – removed from the human side of clinic care – approach healthcare legislation. Participant F explained the supremacy of the Supreme Court's *Roe v. Wade* decision in ultimately deciding what women's abortion rights were. However, he also noted that there is often discord between state and federal laws:

“These laws affecting the clinics will also affect hospitals. If a state law comes along and unduly burdens a clinic, chances are the federal laws will come in and say no, that's creating too much of a burden on a woman's access. State laws will say no, not true, she could go to a hospital to have an abortion done. There may be an interesting conflict, because hospitals may be dragged into this.” (Participant F, 2015)

In addition, Participant F noted that we should not expect to see an end to attempts at overturning the core mandates of the *Roe* decision. He states:

“[Legislators] are going to keep trying to find a back door against [*Roe*] and limit a woman's right. There's nothing wrong with them trying to do it, it's their right. ... The courts are of the view, as they should be, that the U.S. Supreme Court has the final say what the laws are. The Supreme Court has held that, at least for today, a woman's right to abortion will not be unduly burdened. ... The thing that I'm curious about is that it's based on bad science... [The governor] can sign a law saying there are green men on Mars, but that's not unconstitutional. The fact of the matter is that what he's asking doctors to do is factually incorrect.” (Participant F, 2015)

While Participant F's testimony suggests that policymaking is nuanced and complex, he was clear about his view on the interplay between hospitals and clinics. Participant F maintained that clinic closures would not impact hospitals, financially or otherwise (Participant F, 2015). This was an interesting deviation from the statistics in the literature, or from the viewpoints of physicians, but further proves that professional roles shape one's understanding.

Finally, in order to paint a complete picture of the interview process, I will briefly explain why my sample size in the first round of interviewing was fairly limited. This was due, in part, to a great deal of “phone tag” between the individuals who had agreed to speak with me and myself. However, there were also a significant number of advocates, physicians, and legislators who denied my request for an interview, with understandable reasoning. Public figures become vulnerable in interview settings, where the meaning of their statements may be misconstrued – on a topic as sensitive as abortion access, this is not a risk to be taken lightly.

Of the sixteen state delegates I contacted (eight Republican, and eight Democrat), I was only able to reach Delegate Bob Marshall (R), with whom I was ultimately unable to organize an interview. The majority of private practices declined to speak with me, in addition to my local Planned Parenthood. My efforts to create a more equally representative sampling were partially stymied by my inability to arrange an interview with the director of the Virginia Society for Human Life, one of the leading “pro-life” organizations in the state. Similarly, I was turned away from an interview with Americans United for Life, as there was not a lawyer present for interviewing during the day of my visit.

The initial round of interviews, while eye opening and integral for the development of this research as a whole, was incomplete in its representation of the discussion of abortion access. The second round of interviews conducted was not engineered to expand the study size, but rather to target relevant individuals who would deepen and add to the discussion presented in the first round. Unfortunately, difficulties arranging interviews became a recurring theme during the second round, as I was unable

to coordinate an interview among the four delegates (two Republican, and two Democrat) and one Democratic senator that I attempted to reach. I was also unable to organize an interview with the director of a health center that is currently suing the state over TRAP regulations, which I felt would have been a great boon for this research.

The process of engaging in social science research for the first time, reflecting upon that experience, and then returning to it to improve and build upon it has been transformative. As a student, and now as a researcher, I see the importance of not only delving into the literature to understand a topic, but also doing fieldwork that reveals to you firsthand its realities. While the work for this particular research has now come to a close, I am eager to venture forth with the skills and knowledge it has given me. I hope to continue community-based interviewing in the future, and integrate the many voices that exist in every social justice discussion.



## Chapter 5: Conclusion

### Overview

The research presented in the preceding chapters represents work done over the span of close to half of my collegiate years. As the research objectives and scope of this project have shifted and grown, I have changed alongside them. In the beginning, I sought to document the obstacles I encountered, thinking that the list would become shorter as I familiarized myself more with this style of research. However, the list has only grown the deeper I have delved into this work, and I have concluded that research can never truly be done. Below are my first “stumbling blocks,” as written in my first week of research in the summer of 2013:

#### Week 1

- There are no abortion-providing clinics in Winchester. Or anywhere close to Winchester. The closest clinic is in MD, and only provides abortion referral services. The clinic I did find near Winchester is run by a pro-life group and does not offer, refer for, or educate about abortion services.
- Long lag time/lots of phone tag with state delegates and some doctors. Makes scheduling difficult.
- Having accessed all the legislation I could find on VA abortion access, I realized I don't actually have a template for analyzing it. Cornell notes are not suited for it, and I am unaware of any other systematic note-taking method. Going rogue.

Despite my ability to attempt optimistic objectivity at the start of this research, the gravity of the subject matter quickly became apparent to me. I realized that, even when I was successful in arranging interviews or locating useful literature, I would encounter hardship as a result. Every interview I conducted elicited some degree of frustration or sadness from the participant being interviewed, and reminded me of the true nature of

this research. Politics and activism aside, abortion access impacts real people in real, immeasurable ways.

In order to respect the personal and emotional boundaries of this topic, this paper aims to inform through objective analysis of legislation, statistics, and personal interviews. By doing this, the dynamic relationships that exist between state and national laws, as well as between various sectors of the healthcare system, may be better understood. I began my analysis with an overview of Senate Bill 924, or TRAP, the set of regulations currently governing Virginia's abortion-providing, outpatient facilities. I then assessed the interplay that exists between TRAP's impact on women's access to healthcare, and that of the PPACA. In exploring this connection, I was able to focus on the effects of these bills on hospital use, and use current information to make projections for the future. Finally, I used two sets of data from interviews with physicians, advocacy group members, and other relevant professionals to shed light on how these laws were affecting Virginia outside of the courtroom.

In my discussion of TRAP, I addressed the range of reactions that came about in response to the bill's passage. This included the resignation of former Virginia Commissioner of Health Karen Remley, and questions from the pro-choice camp as to whether or not this legislation was more than strategic maneuvering by the GOP. Indeed, since I began work on this research, one clinic has already filed a lawsuit against the state regarding the terms of the bill (Richmond Medical Center for Women, 2015). Due to the aforementioned charge that Governor McAuliffe has given the new Board of Health members, this lawsuit is currently on hold, but speaks to the dissatisfaction of the pro-choice community (Richmond Medical Center for Women Interview II, 2015).

Alternately, predominant pro-life voices have called the passage of the bill “overdue” and “inevitable” (Terrini, 2011). Pro-life advocates will potentially be able to count SB924 as a victory in a long line of attempts at rolling back *Roe v. Wade* since its enactment in 1973.

Beyond the opinions of advocates, TRAP has had real effects on the clinics it was created to regulate. The law has already led to the closure of two clinics, and is predicted to lead to more in the coming year (Richmond Medical Center for Women, 2015). TRAP ultimately hinders clinics’ ability to remain open, in conjunction with related factors limiting access to abortion. These include geographical proximity, financial constraints, and laws mandating 24-hour waiting periods, among other factors (Donohoe, 2005).

One such factor has been the implementation of PPACA, beginning in 2010. While intended to expand health insurance coverage, Medicaid programs, and access to preventive medicine, there are certain dynamics that may be altered by the implementation of this program. One such relationship is the one between hospitals and clinics across the state. These two types of institutions address different needs – i.e. emergency situations vs. primary or outpatient care – and must both exist in a healthcare system for it to be in balance. While TRAP is leading to the gradual closure of Virginia’s women’s clinics, the supply and demand curve for primary care services is likely to be altered. Simultaneously, PPACA’s impact on insurance coverage will likely lead to an increase in patients seeking primary care providers. The supply and demand relationships present in this scenario are important to consider when analyzing the impacts of TRAP and PPACA that are yet to be seen.

The final branch of my research concerns the communication and analysis of the data collected from two rounds of interviews I conducted. I spoke with individuals involved in the discussion of abortion access, ranging from physicians to lawyers, and was able to do so both in 2013 and now in 2015. Their candid answers provided me with insight into common themes that exist in the discussion of this topic. They also further reinforced the fact that this is not a single-issue discussion, regardless of pro-choice or pro-life leanings. The debate surrounding abortion access encompasses women's and civil rights, the separation of church and state, constitutional law, and many other considerations.

The first round of interviews served primarily as an exploratory exercise in social science fieldwork, but it helped to shape the interview schedules for the second round as well. The second round of interviews was intended to expound upon the patterns I extracted from the first round, and to provide additional insights from voices not originally featured. These narratives brought to light many of the lesser-known effects of TRAP, and helped further my understanding of PPACA's current and coming role in our healthcare system.

## **Conclusions**

This paper was originally created for the edification of its readers (and, of course, myself) but there are also concrete conclusions I can point to that have resulted from my research. The first of these is that **TRAP will ultimately limit abortion access in Virginia**. While the bill will likely also accomplish its stated goals of holding abortion-providing clinics to the same safety standards as surgical centers, by doing so, clinics will be forced to close. In an effort to remain objective, I will not speak to whether

or not I believe TRAP is in the best interest of the public, or if I see its terms as reasonable. I will allow the opinions expressed in this paper, as well as the relevant data presented, to speak for themselves.

The second conclusion I have come to is that **politics and abortion are inextricably bound, at least in contemporary United States healthcare.** In the first round of interviews, I spoke with a physician at a pro-life OB/GYN practice who told me, “I just want to make a career practicing what I believe. Just leave us alone and we’ll leave you alone” (Tepeyac Family Center, 2013). Similar sentiments have been expressed by other physicians, through statements in the media and legislative involvements, including those physicians who provide abortions. However, despite an understandable desire to do one’s job unencumbered by red tape or bureaucracy, politics are pervasive. So long as abortion access remains a hot-button issue, it will remain on politicians’ agendas, and resultantly implicate the physicians involved.

The final conclusion I have come to is that **the implementation of PPACA in concurrence with that of TRAP will lead to financial difficulties for our healthcare system.** As both of these laws are still current, and remain subject to change, it is impossible to fully predict the impact they will have on our healthcare system. However, after both the interview process and the legislative review I conducted for this research, I have concluded that, when working in tandem, these laws will stress our emergency departments, primary care networks, and ultimately, the taxpayers. There is always the possibility that counteractive legislation may be passed to correct some of the imbalances in consumer supply and demand curves, but at the time of this paper’s completion, that has yet to be seen.

## Reflections

In concluding this project, there is undeniably much room for rumination on what could have gone better, and what I would do differently had I the opportunity to complete this work again.

The first, and most prominent, complication that arose during this work was my inability to successfully reach legislators and politicians for the first round of interviews. I was tenacious in calling and emailing, but do feel that had I allowed more time for this aspect of the research, I would have had higher chances of success. I was able to reach Delegate Bob Marshall (R) and Senator Creigh Deeds (D), but lost touch with and was turned down by each, respectively. I view the interview process as integral to providing a comprehensive perspective on the matter of abortion access, and learning the opinions of the policymakers involved in it would have been invaluable.

Similarly, the second round of interviews I conducted was much less revelatory than I had anticipated, largely due to a lack of response from the individuals to whom I reached out. I worked to contact Virginia delegates and senators who were directly involved in reproductive healthcare legislation, but did not get a response from any. I also worked to contact a lawyer and the women's clinic currently suing the state over TRAP, but was delayed in arranging interviews with either.

My difficulty in arranging interviews is suggestive of the sensitive and contentious nature of this issue – it also reflects our culture's difficulties with open dialogues on tough subject matter. This has been a meaningful learning experience for me as a student, and novice researcher, but I do wonder how this work would have been enhanced by the input of those in question. I also feel that my own writing was unduly

influenced by the lack of pro-life narratives in either round of research, at times skewing my presentation of this controversial issue.

A more positive takeaway from this work stems from the resources I was able to access through Virginia state courthouses, the Library of Congress's legal library, Swem and Wolf Law Libraries, and the personal documents of physicians I interviewed. It may be possible to complete a literature review simply through the use of online sources, but in order for me to appreciate the history of our state's jurisprudence and the tireless work of those involved, it was necessary to read the primary documents that exist. Those materials I accessed in the first stage of this research informed my creative process in developing this thesis, and hopefully are reflected in my writing.

Finally, there is the element of humanity I have come to appreciate and associate with the legal process. As an outsider to public policy and its inner workings, I entered this process with a limited understanding of what drives people to become involved in legislative work. Now, I see that it is through our legal system that lasting change may be generated. Grassroots efforts and mobilized publics are necessary to raise public awareness about issues and candidate platforms, but until the governed act upon the laws governing them, progress will remain stalled.

The well-known Mark Twain quote, "don't let schooling interfere with your education," feels particularly applicable to my work on this thesis. As I think back on my experiences volunteering as a clinic escort, perusing the court proceedings of plaintiffs I interviewed, and following the lawsuit against TRAP in real time, I realize that my education would have been incomplete without them. In the coming years, I intend to

carry with me the energy that I saw in the individuals involved in this work, so that I may one day be just as active a participant in this discussion.



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