

POLICY AND POLITICS:
THE EFFECTS OF FACILITY REGULATION ON ABORTION ACCESS IN VIRGINIA

A Thesis Presented to the Faculty of Architecture and Planning
COLUMBIA UNIVERSITY

In Partial Fulfillment of the Requirements for the Degree
Master of Science in Urban Planning

by

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May 2013

Policy and Politics: The effects of facility regulation on abortion access in Virginia

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2013

Abstract

Pro-choice organizations claim that by 2014, over half of the twenty health centers providing abortions in Virginia will be forced to discontinue services as a result of a regulation categorizing these facilities as hospitals. Proponents of the regulation claim its purpose is to increase patient safety; however, higher-risk medical procedures, such as cosmetic and dental surgeries, are not subject to similar regulatory scrutiny. This investigation seeks to understand general conditions under which the categorization of abortion providers as hospitals impacts operational costs, as well as bars entry of new providers into the market. Using Virginia as a case study, it also specifically explores how local politics impacts the implementation of health planning, policies, and regulations.

Acknowledgements

I am forever indebted to Professor Smita Srinivas for her guidance, support, and challenge to push further than I ever thought possible. In addition, Dr. Beverly Winikoff was incredibly helpful and insightful in the final stages of the process. I appreciate both of their commitments to this scholarship and to my growth as a researcher.

David Nova of Planned Parenthood Health Systems in Virginia provided many hours of consultation, exploration, and feedback, without which this research would not have been possible. I am grateful to him for his help and for his commitment to providing reproductive health services to the women of Virginia. His and the work of my other sources constantly reminded why I had chosen to study this subject and spurred me to continue on.

Rachel Perera was a fantastic GIS collaborator and helped me work through some of the spatial aspects of the investigation. It is because of her steadfast work that I was able to meet my deadlines. Many many thanks to her and her map-making skills.

I deeply appreciate the hours spent by family and friends reviewing drafts and suggesting feedback; the work is better for it and I have learned from you all. No less crucial to my survival were the people who just listened to me kvetch—that couldn't have been fun, but it was crucial. I thank Amewusika Sedzro for the long days and nights spent brainstorming and pushing each other and for the constant encouragement, especially when I did not believe that I could get it done.

To my husband: This process has pushed me far beyond what I ever imagined I was capable of and I know I would not have made it here without your honesty, (constructive) critical eye, and belief in me. Looking forward to life with you on the other side of thesis!

Introduction and Justification

Abortion is unlike any other medical procedure in the healthcare market. Complex and contentious in nature, it has been considered a health issue, a moral issue, a religious issue, an equality issue, and a feminist issue. Regardless of an individual's opinion on the subject, it is a legal procedure in the United States, and the medical profession and scientific community has deemed it a safe procedure that does not cause long-term adverse effects on a woman's health. I propose that politics impacts the geospatial distribution of services, which, in turn, impacts a patient's ability to access services. Patients with low economic status or patients who lack a supportive social structure are significantly more affected by this than those who have access to resources that allow them to travel long distances and forgo income-earning endeavors to obtain an abortion.

Health planners are responsible for identifying the needs of diverse populations and the costs and benefits of initiatives to develop public health plans. Their reports often form the rationale for local government resource distribution. Though based in biological or environmental sciences, health planners are not apolitical. Their work is directly influenced by politics, the ideological beliefs of major stakeholders in the community, and the subjective interpretations of regulations that govern interactions between political bodies such as the attorney general, the Board of Health, and the health commissioner.

Rather than investigate the “why” or “why not” of abortion, this investigation looks to the regulation of a legal medical procedure and uses the Commonwealth of Virginia as a case study to understand *the conditions under which the Virginia’s categorization of abortion providers as hospitals change the market conditions for providers and increase the barriers for entry for new providers.*

My findings confirmed my hypothesis that these regulations and the efforts to enforce them are biased and inextricably linked to local politics. The projected outcomes are that many abortion providers¹ will incur significant financial impacts which will lead to reductions in reproductive health services or the cessation of abortion provision all together. The geospatial distribution of the remaining providers will impact patients by increasing the cost of the procedure, cause them to delay obtaining an abortion or force them to choose unsafe methods to terminate a pregnancy. Lastly, whether the organization is designated as a non-profit or private facility affects the composition of the market and has an impact on the provider’s ability to comply with the regulation. I propose that in the near future this distinction will also create circumstances that may further endanger access to safe abortions.

What this thesis is and is not about

Since the Supreme Court’s 1973 rulings in *Roe v. Wade* and *Doe v. Bolton*, opponents of abortion have openly used the state’s ability to regulate medical procedures to influence a

¹ The term “provider” can denote the medical doctor providing an abortion, an organization with more than one location which provides abortions as one of its services, or a facility in which an abortion is performed. In this investigation I use the term “provider” exclusively to indicate a facility in which abortions are performed, excluding hospitals. Because hospitals provide relatively few abortions and are unaffected by the hospital-categorization, I do not include hospitals in the count of twenty Virginia providers. Only 1.6% of abortions took place in hospitals in 2011 in Virginia (VDH Vital Statistics).

woman's decision to obtain an abortion (e.g. via mandatory delay, parental notification, and ultrasound requirements to name a few). In addition, they have diversified their strategy by increasingly and openly using the state's power to regulate the provision of abortion via stringent reporting requirements and facility regulations. These requirements have increased the cost to providers, many of which do not pass the increase on to patients because they are non-profit organizations driven by their mission to provide access to reproductive services including abortions. As regulations become more stringent and costly to providers, some will be forced to shut down, dramatically altering the access landscape. Taking into consideration the impacts of these regulations on the safety of the procedure, this investigation seeks to understand the dynamics among state government as regulator, elected and appointed officials with political and ideological motivations, non-governmental healthcare providers, patients, and the local healthcare markets in which these forces intersect.

This thesis is not about whether or not abortion should be legal in the United States, at which point in a pregnancy abortion should no longer be allowed, nor about who should be involved in the decision to have an abortion (parents, spouse, government, etc.). Instead my starting point is the 1973 Supreme Court decisions that (1) legalized abortion (*Roe v. Wade*) and (2) gave the physician the ability to determine the "medical necessity" of the procedure, widening the definition to include emotional well-being in addition to psychological well-being (*Doe v. Bolton*). Both decisions maintained that each state had the right to regulate the provision of abortions. The subsequent Supreme Court decisions on abortion further defined the role of the state: The 1989 decision in *Webster v. Reproductive Health Services* held that states were not

required to facilitate abortion provision. The 1991 decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey* further solidified the state's rights to regulate its provision as long as it did not cause "undue burden" on a woman's access. In *Casey*, the court set the bar very high as to what defines undue burden on a woman. The court ruled that 24-hour waiting periods, parental notification, informed consent did not create undue burden. However, spousal consent did create undue burden for fear that, "husbands could potentially resort to abuse and obstruction upon learning of their spouses' abortion plans."²

These decisions set the stage for each state to regulate the provision of abortion to the degree its elected and appointed officials deemed necessary, giving way to as many ways to regulate abortion as there are states.

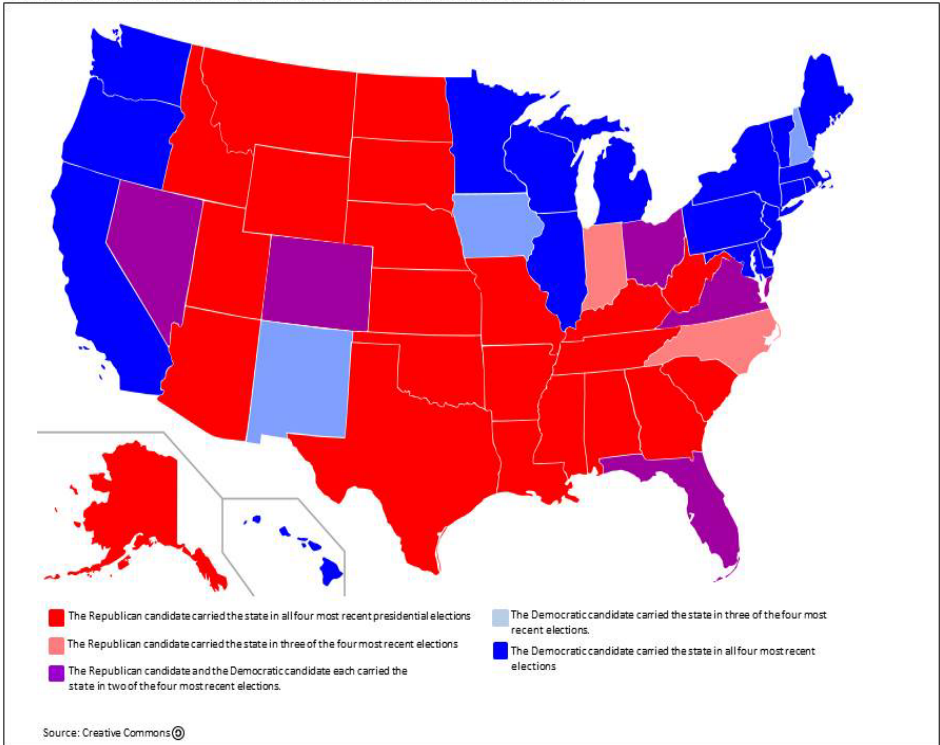
² McBride, A. (n.d.). *Landmark cases: Casey v. Planned Parenthood (1992)*. Retrieved from http://www.pbs.org/wnet/supremecourt/rights/landmark_casey.html

Virginia as a case study

The Commonwealth of Virginia presents several conditions that make it an interesting and compelling case study. Virginia has a relatively heterogeneous political constituency, as opposed to other overwhelmingly conservative states in which one might expect evidence of abortion opponents' actions restricting access (see Figure A1). Starting in 1996, Virginia politicians attempted and failed to categorize and regulate abortion providers as hospitals until December of 2012, when Governor McDonnell signed the regulation into law between Christmas and New Year's Eve. In September of that year, Health Commissioner Dr. Karen Remley had publicly denounced the regulation and stepped down because the regulation did not include a grandfather clause which would have allowed existing providers to continue offering their services. Lastly, because Virginia law does not differentiate between medical (oral drugs) and surgical (a physical procedure whereby the fetus is extracted through the vagina) abortion, facilities which only provide a medical abortion will also be subject to the regulation.

This means that though they are only administering a medication, providers will still have to have a sterile operating room of at least 250 sq. ft. to provide abortions. For example, this is the case in the Blacksburg Health Center of Planned Parenthood

Figure A1: Representation of Presidential votes by state for the 1998, 2004, 2008, and 2012 elections



Health Systems. Because the Blacksburg facility does not currently have an operating room, it will either have to relocate or renovate in order to administer the oral medication. This is just one example of the effects of this regulation, which pro-choice organizations claim will cause a majority of the twenty providers to discontinue abortion provision by 2014, drastically impacting access to abortion for low-income Virginians.

“Targeted Regulation for Abortion Provider” Laws

My interest in these regulations began when I learned that pro-choice organizations use the term “Targeted Regulations of Abortion Providers” (TRAP) to describe them. Bonnie Scott Jones of the Center for Reproductive Rights explains that, “[the TRAP laws] basically...are health facility regulations that apply only to physicians that provide abortions and not to physicians that provide any comparable procedures [such as vasectomies and out-patient cosmetic surgery]. So, they are laws that regulate anything from the staff that the facility must have, the structure, the physical building that the service is provided in to the kinds of written policies and procedures that the facility has -- any sort of health facility regulations like that that apply only to [abortion providers] and not to other facilities...without making abortion any safer at all.”

Abortion is considered to be an extremely safe procedure with a widely accepted 0.1-2.0% risk of complication (National Abortion Federation, 2012). The American Medical Association defines abortion as a procedure performed in an office (non-sterile) setting and its position is that “the Principles of Medical Ethics of the AMA do not prohibit a physician from performing

an abortion in accordance with good medical practice and under circumstances that do not violate the law.”³

“TRAP” laws vary from regulating the minimum size of a patient room, to air filtration requirements, to the ratio of registered nurses to patients on the premises. David Nova of Planned Parenthood Health Systems in Virginia explains, “The requirement of five foot wide hallways is the worst. It is required so that two gurneys can pass each other in the corridor, but most facilities only have one gurney. It’s a real burden to providers [who don’t already have wide corridors]. It will cause some centers to close.” This seemingly minor regulation alone creates a situation in which providers either have to (1) fight the provision within a system of interconnected health institutions that are politically and ideologically opposed to abortions and thus not likely to grant a temporary variance, (2) invest financial resources to widen the

Figure A2: Examples of regulations on abortion providers and their effects on patient safety and providers.

| State | Example of TRAP law | Effect on patient safety | Effect on Abortion Provider |
|----------------|---|------------------------------|--|
| South Carolina | "Prior to the [abortion] procedure, laboratory tests shall include...[d]etermination of Rh factor (including the Du variant when the patient is Rh negative) and . . . [t]esting for Chlamydia and gonorrhea. . ." S.C. Reg. 61-12 § 304-C | No impact on patient safety. | Increase costs to provider in personnel time and lab costs. |
| North Carolina | Abortion procedure and recovery rooms shall have a minimum of six air changes per hour, and "all air supplied to procedure rooms shall be delivered at or near the ceiling" and must pass through "a minimum of one filter bed with a minimum filter efficiency of 80 percent." 10 N.C. Admin. Code 3E.0206 | No impact on patient safety. | Increase costs to provider in supplies, HVAC system. |
| South Carolina | "All outside areas, grounds and/or adjacent buildings shall be kept free of rubbish, grass, and weeds that may serve as a fire hazard or as a haven for insects, rodents and other pests." S.C. Reg. 61-12 § 606 | No impact on patient safety. | Increase costs to provider for landscaping and outside maintenance; even if facility located in office building. |
| Texas | Licensed facilities must ensure that all patients are cared for in a manner that "enhances [the patient's] self-esteem and self-worth." 25 Texas Admin. Code §139.51 | No impact on patient safety. | Ambiguous outcome required/impossible to measure. Increase cost in personnel time. |
| Virginia | Licensed facilities must have hallways at least 5' wide. | No impact on patient safety. | Increase cost if renovations or relocation necessary to comply. |

³ American Medical Association website, Accessed 2-9-13. <http://my.ama-assn.org/myama/priv/articles/obstetrics-gynecology.page>

hallways (assuming the provider owns the building), or (3) move to a facility that is built to the specifications. The regulation does not improve the already safe procedure, but it does require providers to divert human and financial resources in order to fight or meet the regulations, which in turn has an impact on the organization's ability to provide abortions or other reproductive health services. Figure A2 lists some examples of the regulations and their effects on patient safety and providers.

The nature of abortion further complicates the system in that the patient determines the need and often seeks out the specific service; physicians do not prescribe abortions. Studies explored further in the Literature Review have confirmed that the demand of abortion is inelastic. That is, changes in the supply of abortion do not impact the demand. Thus, if a patient seeking an abortion does not have access to the service (either due to proximity or cost) they will likely seek an abortion at a greater distance, incurring higher opportunity cost and actual costs, or they may seek illegal and potentially dangerous termination methods. These obstacles may also cause patients to delay the procedures to the second trimester, which also increases the procedure's complexity and risk. Because each state has the freedom to regulate healthcare provision as its policy makers and bureaucrats see fit, there are a myriad of ways in which political ideology and personal beliefs have impacted the provision of this legal and safe, albeit controversial, procedure.

Thus if abortion provision is not made safer by these regulations and providers are forced to spend more money and human resources to either comply with the regulations, fight them in court, or stop providing abortions altogether, what is the environment in which local health

planners and physicians can maintain reasonable access for patients seeking abortions? In order to fully understand the basis for the regulations, why pro-choice organizations felt they were onerous and egregious, and how the regulations affected the landscape of access, this investigation seeks to understand the mechanisms by which elected officials and bureaucrats regulate healthcare, and then projects scenarios of the likely impacts on providers in Virginia.

Literature Review

I conducted my literature search using Columbia University's *Find Articles* function, which searches all available databases at once. Previously, I conducted literature reviews on themes of *women, access, health information-seeking behavior, help-seeking behavior, United States, preventative, prevention, primary healthcare, ethics, values, social justice, equity, and abortion*. While these articles have influenced the development of this research, this literature review is based on searches as a result of different combinations of the following terms: *planning, regulation, health, healthcare market, bureaucrats, and bureaucracy* and were filtered to retrieve only journal articles and dissertations in English. The articles selected were those whose titles and abstracts were related to the general theme of planning regulation and health planning. The bibliographies of each article were also searched for additional sources. The themes that emerged from these articles set the stage for the exploration of institutional dynamics that impact access to abortion in the Findings Section of this investigation.

Decentralization of Healthcare and Local Politics

One source of tension unique to healthcare in the U.S. is the divergence between federal laws and state regulations, which are inextricably dependent on local politics. Fontana (1986) makes the link between health planning and politics explicit in his article, "Political ideology and Local Health Planning in the United States." He notes that the American health system is based on allowing variance of political values from one community to the next. "The presumed differences in ideology among consumers and providers of health services has been the foundation for the development of a national network of health planning agencies in the United States [since the] Health Planning and Resources Development Act of 1974 created a system of over 200 independent, government-financed public and private organizations known as Health Systems Agencies (HSAs)." He notes that this is uniquely American; in other developed countries healthcare is centralized. He continues, "The American planning agencies, however, claim independence from government since the government is seen as but one of a number of 'interests' in the healthcare sector." He concludes that, "although the rhetoric of health planning exalts rationality, health planning at times is highly controversial. Issues arise in which the selection of both means and ends involve conflicting values and priorities."

Solomon et al. (1998) conducted case studies on several local markets and their findings strongly suggested that "public policy is an important force that shapes [local] health system change, for instance, by establishing the underlying 'rules of the game' for private and public actors and by influencing the decisions of national and regional entities to enter and exit local markets." These 'rules' heavily influenced entry and exit in the local healthcare markets. I

believe this to be congruent with North's (1994) assertion that, "It is the interaction between institutions and organizations that shapes the institutional evolution of an economy. If institutions are the rules of the game, organizations and their entrepreneurs are the players. Organizations are made up of groups of individuals bound together by some common purpose to achieve certain objectives."

Rising Costs for Community Health Providers

Politics and institutional dynamics are not the only reason that healthcare cannot be considered a traditional market. Varying procedure costs and reimbursement schemes to the provider are central to its uniqueness and complexity. "U.S. healthcare has long featured a struggle between regulation and markets as vehicles of reform, and the community hospital is at the center of this struggle" (Choudhry et. al., 2005). Choudhry et al. hypothesize that the key to financial viability of the community hospital is "cross subsidization," which they describe as using "profits from well-compensated services to support those operating at a loss." This article focuses on the community hospital's loss of these well-compensated services such as radiology, orthopedic procedures, and endoscopies to ambulatory surgical facilities that provide the services at lower rates. The cross-subsidization in healthcare is akin to a traditional market in which higher profit margins on products offset lower profit margins on others. In addition to the aggregation of profits over the entire inventory, the diversity of products is necessary to attract customers. For example, a food market offers fruits and vegetables at a lower profit margin than packaged goods; this variety attracts customers who are interested in both and allows the market to make a profit on its array of products. However, healthcare is

not often purchased in bundles as food is. Also, consumers often do not pay for healthcare directly, further complicating the market structure.

Choudhry's analysis can also be applied to understand the disadvantage faced by an abortion provider driven by mission (such as a non-profit). Reproductive health centers providing abortions face the exact opposite circumstances as specialty ambulatory surgical facilities: where surgical facilities have become more profitable by treating higher volumes of profitable cases, low-severity cases, and patients with generous insurance coverage,⁴ many reproductive health centers are mission-focused to serve uninsured/underinsured patients often paying out of pocket on a sliding scale. They cannot cross-subsidize by virtue of their mission.

The Market in Which Abortions are Provided

In purely economic terms, a market is a space in which buyers and sellers trade or exchange goods, services, and information. However, markets are comprised of much more than the "buyers" and "sellers." In the case of abortion provision, the state government is instrumental as regulator and subsidizer, in limited cases. Also, philanthropic organizations, advocacy groups, religious institutions, and other special-interest organizations on both sides of the debate can play roles in financing initiatives or providing in-kind support. The provider can be considered both the "seller" and the "buyer," in that a patient obtains services from the provider but the provider is also regulated by The State, thereby seeking various permits, licensure, certification, or authorizations to operate from The State. Further complicating this system, there are different types of providers: private and public hospitals, non-profits health centers driven by a

⁴ Mitchell, J. (2005). Effects of physician-owned limited -service hospitals: Evidence from Arizona. *Health Affairs*.

mission to provide an array of reproductive healthcare including abortions to underserved populations, and private physician's offices operating without non-profit status. An organization's type, size, and its affiliations impact the cost of providing the service, the cost to the patient, and how opponents may focus efforts to challenge their work.

Planned Parenthood-affiliated healthcare providers can also be considered a special case. As individual providers operating within affiliated regional blocks, each facility raises its own donations to support its services. As the umbrella organization, Planned Parenthood Federation of America (PPFA) accredits facilities and provides legal and lobbying efforts at the national and state level, as well as promoting the Planned Parenthood brand.⁵

The distinction between non-profit and physician's office is critical in assessing the potential impacts of the regulations in Virginia. Providers which are mission-driven often provide a variety of services that are non-income generating (such as educational initiatives) and are committed to serving populations that would not otherwise have access to reproductive health services. Thus, they often offer a sliding pay scale to patients, relying on donations and grants to subsidize the cost of service provision. As their costs to provide abortions increase, they do not raise their fees to patients in need in order to cover their costs. On the other hand, providers that do not operate under a mission to provide underserved populations may have the ability to increase fees as their costs increase.

Abortion Inelasticity and the Costs of Abortion

⁵ The Planned Parenthood "brand" does not necessarily serve affiliates, especially in states with significant opposition to abortion. In 2013, Texas lawmakers successfully defunded any organization advocating for abortion access, even if they did not provide abortions. This is explored further in the Discussion Section.

Levine (2004) makes an important distinction between the public and private fiscal costs of abortion. In economic terms, the public costs would be considered externalities. The different costs can be separated out into three perspectives: the private costs associated with not having an abortion (borne by the individual), the public costs associated with an individual not having an abortion (borne by society), and the private cost of the procedure including the money paid to the provider, cost of transportation, overnight accommodations if necessary, and lost wages (borne by the individual).

In addition, the provider performs the procedure at a cost. As mentioned above, because many providers are mission-driven to specifically serve uninsured/underinsured patients often paying out-of-pocket on a sliding scale, the provider is not likely to pass an increase in cost on their side to the patient. Thus, when providers are faced with increasing costs, they must subsidize abortion services with donations, reduce other reproductive or preventative services, reduce abortion services, and/or discontinue services.

Levine is one of a growing number of scholars looking at the economics of abortion. In his 2004 article, "Abortion Politics and the Economics of Fertility," he proposed that one way to operationalize an undue burden is to consider how policy affects individual behavior.⁶ Much of the research and modeling done on access to abortion and its effects on abortion rates focus on how the increase in cost to the individual impacts their behavior *pre-conception* (e.g. their

⁶ "Undue burden" is in reference to the 1992 Supreme Court decision *Planned Parenthood of S.E. Pennsylvania v. Casey* in which the court deemed states could regulate abortion as long as they did not impose "undue burden" on women. The court failed to define a threshold which would constitute "undue burden," instead ruling on specific Pennsylvania regulations as causing or not causing undue burden.

decisions to participate in unprotected sex and/or use of contraception). Levine and Lichter et al. (1998) separately assert that legalizing abortion and making it more accessible increases sexual activity and/or reduces the use of contraception because people then use abortion as a form of insurance against unwanted pregnancy (being that insurance's primary feature is to protect people from downside risk). Kearney and Levine (2012) conclude that other policy interventions, including sex education, abstinence and State Children's Health Insurance Program (S-CHIP) implementation, are "not found to have a statistically significant, causal impact on fertility."

Levine applies standard economic models to predict how changes in abortion policy at the state level may impact individual decision making. His model is based on the assumption that decision making (specifically, the decision to have unprotected intercourse) is based on a rational weighing of the "relevant costs and benefits of an individual's actions." This assumption also presumes that all parties have perfect information about the consequences of sex, which is not the case. If we were to only look at state to state variations on sex education laws, we can easily see that information on the consequences of sex is distributed in an uneven and sometimes ad-hoc manner.

I also take issue with another of Levine's assertions: he claims that a woman's decision to have an abortion is relatively straightforward: If the cost of the abortion is less than the cost of having an unwanted child, a woman will choose to have an abortion. Conversely, a woman who wants to have a child views birth as a benefit and to her an abortion would be an "irrelevant" option. This binary view of a woman's decision as to whether or not to have an abortion lacks

the nuances and conditions that may impact such a decision. For example, a woman may *want* a child, but not feel prepared to financially and/or emotionally support a baby *at that point* in her life. His view also assumes that the costs of obtaining an abortion is held constant, which it is not. Abortion becomes increasingly complicated and expensive as the pregnancy progresses. As in the following example, sometimes patients delay abortions because they cannot afford the cost of an early abortion, only to find that they have to pay more since they are further along in the pregnancy: “Marie,” a young mother with two children, found out she was pregnant in late December. She needed to collect two paychecks before she could pay for the abortion. By the time she had enough money and got an appointment for February 3, she had just missed the first trimester cutoff. The abortion would now cost her an additional \$200 (Towey et al, 2005).

There is no data that provides evidence that an increase in cost of an abortion to the individual decreases their demand for abortions *after conception*. For example, Medoff (2010) found that mandatory delay laws did not impact the number of patients seeking abortion. In 2012, Joyce conducted research on the supply side, analyzing the effects of the 2004 Texas Woman's Right to Know Act (WRTK), which reduced the number of 2nd trimester abortion providers. Joyce proved that the reduction in supply did not affect the demand; it only displaced it to other states. WRTK effectively increased the geographic barriers to abortion from an average straight line distance of 33 miles to 252 miles without decreasing the (already low) risk of complication. These, and other similar studies, provide evidence that regulations designed to dissuade a patient from obtaining an abortion after conception are not effective.

Traveling long distances to obtain abortion services is not unique to American women. Grossman et al. (2012) conducted interviews with patients of a San Diego, California provider to better understand why Mexican women were crossing the border to access abortion services. Most of the women sought services in the U.S. because they mistrusted services in Mexico and because they wanted access to a medical abortion.⁷ (Mifepristone, the drug used in a medical abortion is not legal in Mexico).

In some cases, the regulation or obstacles to access abortions cause women to attempt a self-induced abortion, which, at best, can lead to incomplete abortions or at worst, can lead to life-threatening infection and long-term damage to the reproductive track. The findings from a 2010 study on the reasons why women attempt to self-induce abortion indicate that younger women did not feel comfortable or did not think they could obtain parental consent (even in states in which parental consent was not mandatory) (Grossman et al., 2010). Three women were told they would not be able to obtain an abortion, while a third of the women interviewed described financial barriers to access an abortion via provider as a factor influencing their decision. Most women described feelings of desperation upon learning of the pregnancy.

Though this is very uncommon in the U.S. (less than 3% of about 1.2 million abortion patients report using self-induction), a closer look at the demographics of the women interviewed suggests that the women who feel that their only solution is self-induced abortions are largely minority and women with low incomes. Of the 30 women interviewed, 26 (87%) self-identified as Latina/Hispanic, African-American, African, Asian-American, Pacific Islander, or Cherokee

⁷ Except for Mexico City, abortion is legally restricted in Mexico (Grossman et al., 2012)

Indian; 21 (70%) had attempted self-inducement between the ages of 16-25, and 14 (46%) received government welfare assistance at the time.

It remains to be seen how a reduction in the supply of legal abortion providers due to facility regulations will impact the demand for abortions. No research has been completed on regulations categorizing abortion providers as Ambulatory Surgical Facilities or hospitals because these regulations are new and the effects are yet to be seen. However, we can surmise from the evidence from studies referenced above that a reduction in abortion providers will not have an effect on the demand *after conception*, though it is likely to increase the cost to providers and patients.

Abortion opponents choose to focus on the lost intangible benefits to society that the individual may have contributed and the more concrete economic contributions such as taxes paid, addition to the workforce, and contributions to social security. Burkett (1998) quantifies this: “Indeed, it is largely because of abortion-on-demand [since 1973] that by the year 2030 the ratio of workers to Social Security beneficiaries will be reduced to only 2-to-1, according to a projection from the Social Security Board of Trustees. In other words, two workers will be supporting one retiree. (When the program began in the 1930s, 42 workers supported each retiree.)” Blogger Joe Miller goes as far as saying that if the 50 million abortions had not been performed since 1973 the U.S. would have a higher GDP, which would “greatly help reduce the burden of our government spending.”

However, pro-choice advocates would mirror this loss with the opportunity cost of the mother’s educational attainment, earning potential, or ability to provide for other children. As to the

societal costs, preliminary results from the *Turn Away* study from the University of California at San Francisco have demonstrated that women who sought out an abortion but were not able to access it are “statistically more likely to wind up unemployed, on public assistance, and below the poverty line,” says lead researcher Dr. Diana Greene Foster. “Another conclusion we could draw is that denying women abortions places more burden on the state because of these new mothers' increased reliance on public assistance programs.”

According to a 2008 study conducted by the Guttmacher Institute, a majority of women accessing abortion services are poor or have a low income. In addition, a majority of women pay for abortions out-of-pocket. As indicated in Figures B1 and C4, the cost of an abortion varies depending on provider type and the gestational age of the fetus. The cost of a procedure is often conversely related to the number of abortions a facility provides. Medical abortions are also more expensive than early surgical abortions (before 10 weeks). In the case of medication abortions in physicians’ offices and providers with small case loads, the authors speculate that the lower cost is a result of providers, “specializing in medication abortion and, in turn, [charging] more for a surgical abortion because it requires more training and specialized equipment” (Jones and Kooistra, 2011).

The spatial distribution of providers and their proximity to public transportation also impacts the cost to the patient, especially those with low-incomes and few social resources. When patients are required to travel longer distances due to low density of providers, they incur higher transportation costs and the cost of their time away from work or additional costs such as child care.

Figure B1: Charges and average amount paid for nonhospital surgical abortions at 10 and 20 weeks' gestation and for early medication abortions, 2009

| Provider type and caseload | 10 weeks — surgical | | | 20 week — surgical | | Early medication | | |
|----------------------------|---------------------|--------------|------------|--------------------|---------|------------------|--------|------------|
| | Charge | | Paid, Mean | Charge | | Charge | | Paid, Mean |
| | Mean | Median | | Mean | Median | Mean | Median | |
| All | \$543 | \$470 | \$451 | \$1,562 | \$1,500 | \$506 | \$409 | \$483 |
| Provider type | | | | | | | | |
| Abortion clinics | 430 | 425 | 428 | 1,555 | 1,500 | 468 | 450 | 472 |
| Other clinics | 535 | 475 | 502 | 1,601 | 1,525 | 511 | 500 | 513 |
| Physicians' offices | 683 | 535 | 550 | 1,535 | 1,500 | 542 | 500 | 463 |
| Caseload | | | | | | | | |
| 1–29 | 747 | 629 | 761 | u | u | 580 | 500 | 594 |
| 30–399 | 551 | 475 | 515 | 1,623 | 1,500 | 496 | 500 | 484 |
| 400–999 | 485 | 450 | 486 | 1,550 | 1,650 | 498 | 475 | 496 |
| 1,000–4,999 | 447 | 430 | 448 | 1,584 | 1,525 | 482 | 475 | 483 |
| ≥5,000 | 415 | 400 | 419 | 1,271 | 1,100 | 468 | 450 | 474 |

Note: u=unavailable because cases are too few to produce reliable figures. The study weighted cost data by number of abortions to account for the fact that more women obtain abortions at facilities with lower charges.

Source: Jones, R., Kooistra, K. (2011). Abortion incidence and access to services in the United States, 2008. *Perspectives on Sexual and Reproductive Health* 43 (1): 41-50.

Example of Regulation and Politics Impacting Access: Admitting Privileges in Tennessee

An example of the tension between regulation, politics and access is Tennessee's 2012 "Life Defense Act." The act requires any physician who performs abortions to be a member of a local hospital, though it does not apply to any other out-patient procedure including cosmetic surgeons, dentists, oral surgeons, urologists, or orthopedic surgeons. Although it is framed as a way to ensure the safety of the patient in the event of complications, hospitals are allowed complete discretion as to whom they give admitting privileges, and many hospitals "will close their doors to doctors who provide abortions" (Stackpole, 2012). Even if the decision to grant admitting privileges were purely economic, hospitals grant admitting privileges to doctors who bring in business, and because those who provide abortions rarely, if ever, need to bring their patients into the hospital due to complications, there simply isn't a business case to grant the privileges. This means that any hospital that provides admitting privileges would probably need to go out of their way to make an ideological choice supporting the facilitation of abortions.

Thus, we find ourselves in a Catch-22. Tennessee is not required to facilitate abortions and non-government organizations are allowed to provide them within the state's regulations. However, the regulations require a hospital within 30 miles to grant admitting privileges, and hospitals are not likely to do that without ideologically supporting access to abortions. The politics of abortion is inextricably tied to the regulation and vice-versa.

The literature on health care decentralization in the United States, healthcare market dynamics, and policy impacts on the supply and demand of abortion set the stage for the exploration of

the institutional dynamics in Virginia which impact the regulation of abortion provision and a patient's access to abortions.

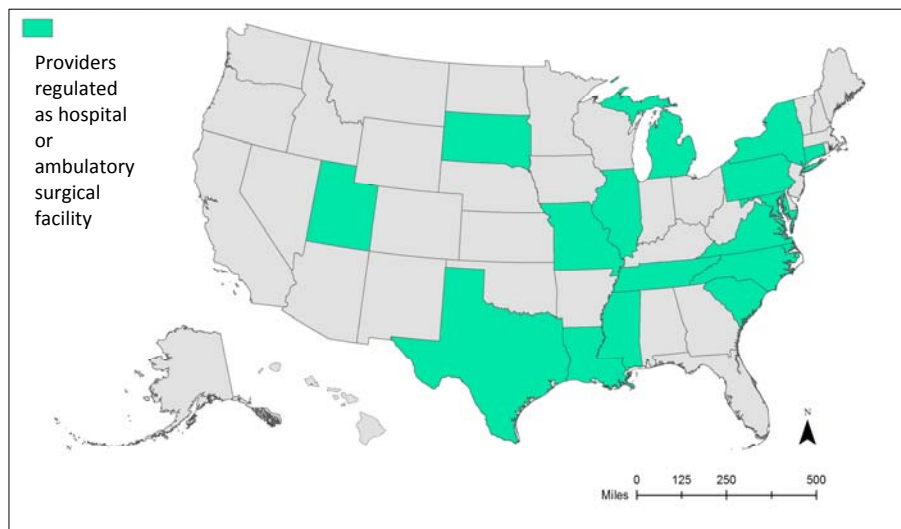
Research Design and Methodology Description

The methods used in this investigation are open-ended interviews, and archival, policy, legislative, and regulatory analysis. In order to understand the current conditions in the U.S., I surveyed the regulations by state, reviewed periodicals and conducted preliminary interviews from November 2012-January 2013⁸ to answer the following questions: (1) what are the regulations that pro-choice organizations define as "TRAP" laws and how do they affect

provision and patient safety? and (2) Are there any states in which TRAP laws are particularly stringent/onerous?

Based on the survey of regulations, periodical

Figure B1: States that are already or in the process of adopting regulation that categorize abortion providers as hospitals or ambulatory surgical facilities.



review and interviews, I determined that pro-choice organizations and advocates overwhelmingly felt that the ambulatory surgical facility (ASF)/hospital categorization of abortion providers was the most onerous and I chose to focus on states that had already or were in the process of

⁸ Interviews conducted are listed in Appendix A by date.

passing these regulations for first trimester pregnancies, when 89% of abortions occur (Guttmacher, 2012). As Figure B1 demonstrates, there are 16 states that either categorize a provider as an ASF/hospital or require that abortions take place in hospitals (some states base this on the gestational age of the fetus). I calculated the standard deviation of the year-to-year changes in number of providers in each state and selected the eight states with the largest variance in providers as “semi-finalists” to evaluate as the subject for this case study (see Figures B2 and B3).

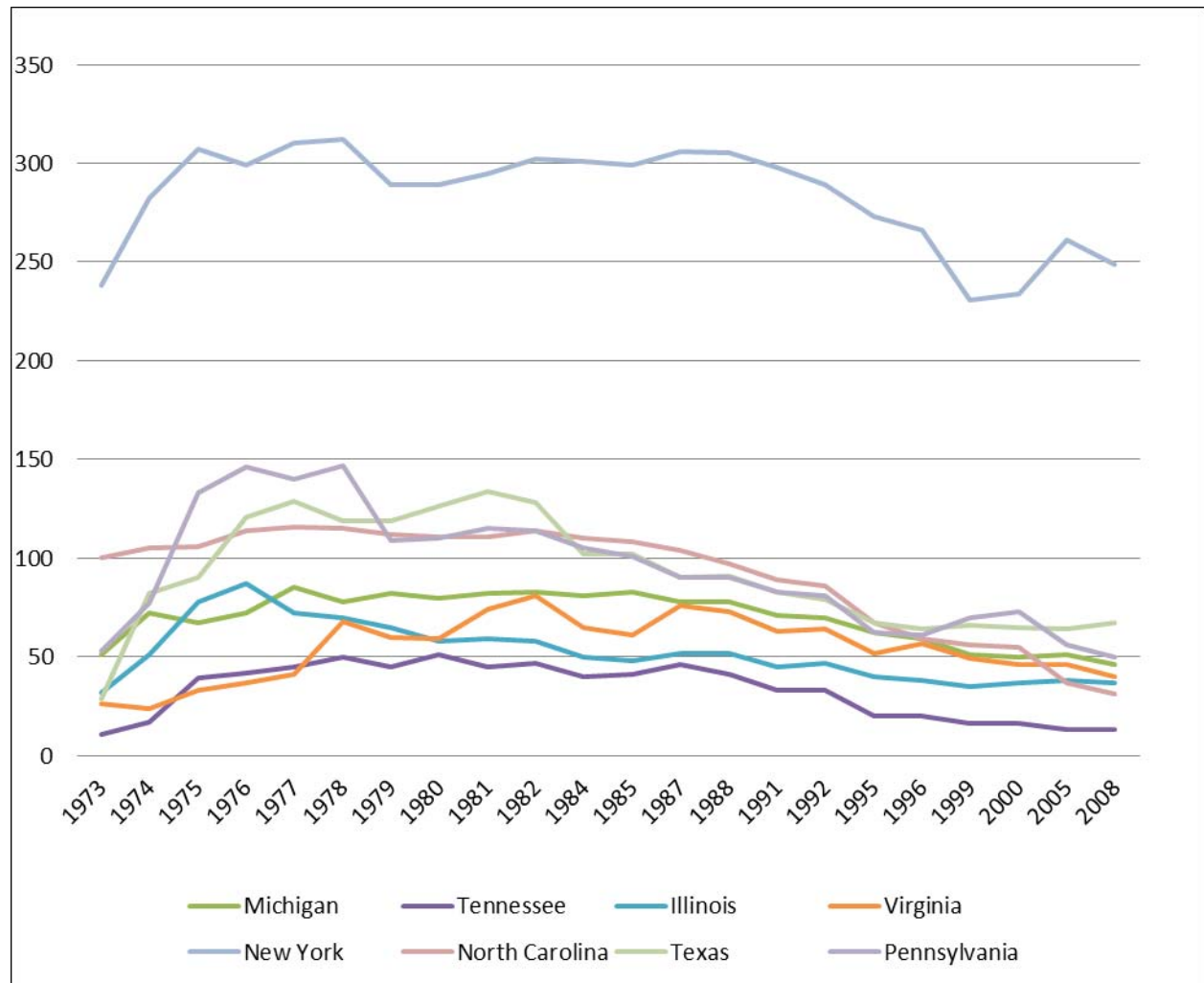
Figure B2: Number of abortion providers* in states that categorize abortion providers as hospitals or ambulatory surgical facilities, 1973-2008

| | 1973 | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 | 1980 | 1981 | 1982 | 1984 | 1985 | 1987 | 1988 | 1991 | 1992 | 1995 | 1996 | 1999 | 2000 | 2005 | 2008 | Standard Deviation | Mean | Max | Min | Diff/ between min and max |
|-----------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|--------------------|------|-----|-----|---------------------------|
| SD | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 0.5096 | 1 | 2 | 1 | 1 |
| UT | 4 | 6 | 6 | 7 | 7 | 6 | 5 | 5 | 7 | 7 | 7 | 7 | 8 | 8 | 7 | 6 | 7 | 7 | 4 | 4 | 6 | 7 | 1.2024 | 6 | 8 | 4 | 4 |
| MI | 2 | 5 | 6 | 10 | 10 | 10 | 9 | 9 | 14 | 13 | 9 | 8 | 6 | 5 | 7 | 8 | 6 | 6 | 4 | 4 | 2 | 2 | 3.3162 | 7 | 14 | 2 | 12 |
| SC | 11 | 12 | 16 | 18 | 18 | 14 | 16 | 15 | 15 | 15 | 12 | 12 | 15 | 15 | 20 | 18 | 19 | 14 | 12 | 10 | 6 | 6 | 3.7222 | 14 | 20 | 6 | 14 |
| LA | 0 | 7 | 10 | 14 | 19 | 14 | 14 | 16 | 17 | 18 | 16 | 15 | 13 | 13 | 16 | 17 | 14 | 15 | 12 | 13 | 9 | 7 | 4.3566 | 13 | 19 | 0 | 19 |
| MO | 5 | 12 | 16 | 21 | 22 | 26 | 22 | 27 | 25 | 29 | 26 | 25 | 20 | 20 | 15 | 12 | 10 | 10 | 7 | 6 | 7 | 6 | 8.0352 | 17 | 29 | 5 | 24 |
| MD | 27 | 34 | 34 | 37 | 43 | 44 | 51 | 52 | 52 | 52 | 48 | 48 | 54 | 53 | 52 | 51 | 46 | 47 | 42 | 42 | 41 | 34 | 7.6356 | 45 | 54 | 27 | 27 |
| CT | 11 | 22 | 37 | 38 | 48 | 49 | 44 | 45 | 46 | 46 | 47 | 47 | 45 | 43 | 43 | 43 | 39 | 40 | 50 | 50 | 52 | 47 | 9.4038 | 42 | 52 | 11 | 41 |
| MI | 51 | 72 | 67 | 72 | 85 | 78 | 82 | 80 | 82 | 83 | 81 | 83 | 78 | 78 | 71 | 70 | 62 | 59 | 51 | 50 | 51 | 46 | 12.9524 | 70 | 85 | 46 | 39 |
| TN | 11 | 17 | 39 | 42 | 45 | 50 | 45 | 51 | 45 | 47 | 40 | 41 | 46 | 41 | 33 | 33 | 20 | 20 | 16 | 16 | 13 | 13 | 14.0743 | 33 | 51 | 11 | 40 |
| IL | 32 | 51 | 78 | 87 | 72 | 70 | 65 | 58 | 59 | 58 | 50 | 48 | 52 | 52 | 45 | 47 | 40 | 38 | 35 | 37 | 38 | 37 | 14.9345 | 52 | 87 | 32 | 55 |
| VA | 26 | 24 | 33 | 37 | 41 | 68 | 60 | 59 | 74 | 81 | 65 | 61 | 76 | 73 | 63 | 64 | 52 | 57 | 49 | 46 | 46 | 40 | 16.2198 | 54 | 81 | 24 | 57 |
| NY | 238 | 282 | 307 | 299 | 310 | 312 | 289 | 289 | 295 | 302 | 301 | 299 | 306 | 305 | 298 | 289 | 273 | 266 | 231 | 234 | 261 | 249 | 25.8100 | 283 | 312 | 231 | 81 |
| NC | 100 | 105 | 106 | 114 | 116 | 115 | 112 | 111 | 111 | 114 | 110 | 108 | 104 | 97 | 89 | 86 | 67 | 59 | 56 | 55 | 37 | 31 | 27.1880 | 91 | 116 | 31 | 85 |
| TX | 29 | 82 | 90 | 121 | 129 | 119 | 119 | 126 | 134 | 128 | 102 | 102 | 90 | 91 | 83 | 79 | 67 | 64 | 66 | 65 | 64 | 67 | 28.1431 | 92 | 134 | 29 | 105 |
| PA | 53 | 77 | 133 | 146 | 140 | 147 | 109 | 110 | 115 | 114 | 105 | 101 | 90 | 90 | 83 | 81 | 62 | 61 | 70 | 73 | 56 | 50 | 30.4285 | 94 | 147 | 50 | 97 |

*A provider is a hospital, clinic or physician's office where abortions are performed.

Source:(For 1973-2008) Abortion Incidence and Access to Services in the United States, 2008, Jones RK and Kooistra K, 2011, Jones RK and Kooistra K, 2011

Figure B3: Number of abortion providers* in states that categorize abortion providers as hospitals or ambulatory surgical facilities, 1973-2008

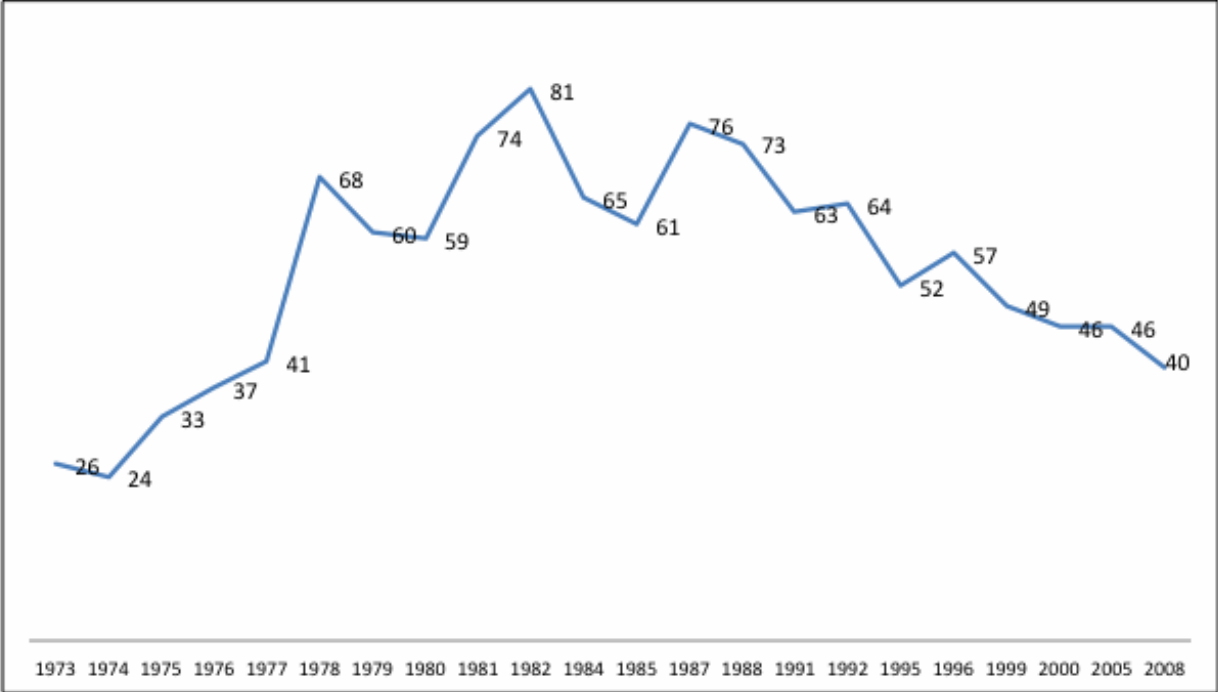


Source: Guttmacher Institute

Each state presented conditions in which there were significant administrative regulations and the number of providers had been decreasing steadily over the past three decades. Based on this survey and conversations with subject matter experts, Virginia stood out for a number of reasons: (1) it has a heterogeneous political constituency (relative to the other states under consideration), (2) the health commissioner had very publicly denounced the newest hospital requirement and stepped down in September 2012 as a result of the lack of a grandfather clause that would have allowed current providers to continue offering their services, (3) it was

the only state that required compliance to specific sections of the Facilities Guidelines Institute *Guidelines 2010* Document, (4) the language in the regulation also provides for a temporary waiver, (5) Virginia does not distinguish between medical and surgical abortions, and (6) pro-choice organizations claimed that the majority of providers (anywhere from 15-20 of 20) were in danger of being forced to discontinue abortion services as a result of the regulation. The significance of these conditions is discussed in the Findings Section. Figure B4 depicts the number of providers in Virginia from 1973-2008.

Figure B4: Number of abortion providers in Virginia by year, 1973-2008



A provider is a hospital, clinic or physician's office where abortions are performed.
Source: Abortion Incidence and Access to Services in the United States, 2008, Jones RK and Kooistra K, 2011, Jones RK and Kooistra K, 2011

I then had to narrow and revise my research question to:

Under what conditions does Virginia's categorization of abortion providers as hospitals change the market conditions for providers and increase the barriers for entry for new providers?

I conducted interviews, analyzed regulation, reviewed Virginia Department of Health documentation (obtained via Freedom of Information Act requests) in order to answer a series of sub-questions:

- Which organizations currently provide abortions in Virginia?
- What resources are necessary to comply with the ASF/hospital requirement for current providers?
- Will providers be forced to cease abortion provision because of the cost of complying with the hospital categorization?
- Is the ASF/hospital categorization used for other comparable out-patient procedures?
- What are the barriers to entry for new providers? How are new hospitals licensed?

In the event that I was not able to establish contact with a particular provider to determine the effects of the regulation on their facility and ability to continue providing abortions, I used property information from www.loopnet.com, a commercial real estate listing database, to determine whether the provider leased or owned the facility. This determination is critical because if a provider leased the property, they would not be able to make significant renovations and would need to relocate to a new facility, which would increase the cost of compliance. Because data about ability to comply was limited, I projected likely outcomes (assuming AG Cuccinelli wins the Gubernatorial election in November 2013) based on (1)

whether the facility was leased or owned, (2) the renovations needed as listed on *Statement of Deficiencies and Plan of Correction* documents obtained by Freedom of Information Act requests for all providers in February 2013, and (3) archival review including quotes in periodicals from health facility administrators stating likely outcomes as a result of the regulation.

Proponents of the regulation were contacted in order to determine their views on the benefits of the regulation (see Appendix B). To date, no contact has been established with proponents of the regulations. As a proxy for their positions, I reviewed and cataloged public comments made in support of the regulation through the Virginia Regulatory Town Hall website (<http://townhall.virginia.gov/>). The public comment period occurred from January 28, 2013 to March 29, 2013.

In order to determine whether these regulations were onerous, I wanted to understand how other procedures with similar risk of complications and fatality was regulated in Virginia based on the data available. If other procedures were regulated with the same parameters as abortions, I could conclude that the abortion providers were not being singled out, whereas if other procedures were regulated to a lesser extent, I would be able to prove that the pro-choice organizations' assertions that these were targeted regulations against abortion providers were correct.

In order to determine whether comparable surgical procedures were regulated in a similar fashion in Virginia, I reviewed journal articles on the risk of complication and fatality of surgical procedures that take place in doctors' offices and ambulatory surgical facilities in Virginia

including plastic surgeries and dental surgeries. Then I reviewed the regulation governing these procedures to determine the similarities and differences between their regulation and the regulation of abortion providers.

Findings

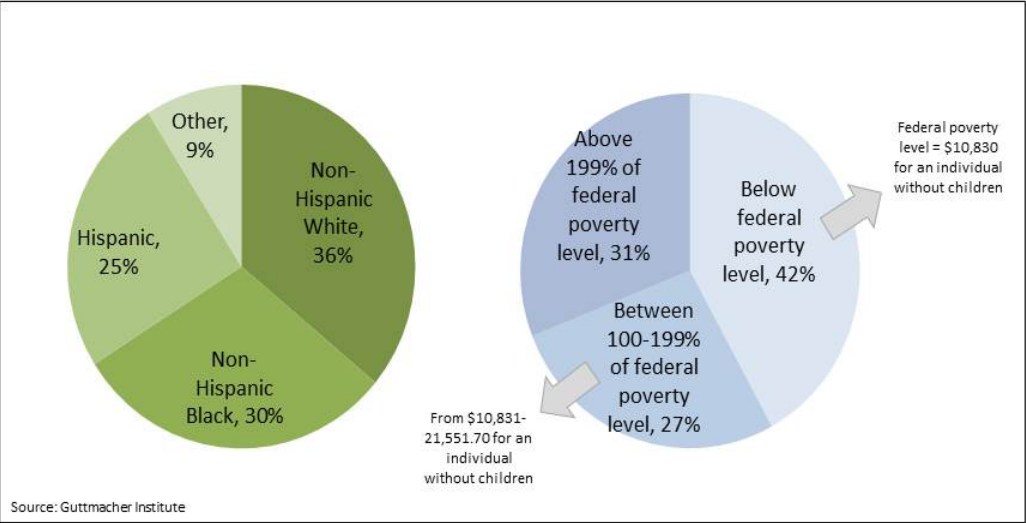
Following is a situational analysis of Virginia’s political and health regulation landscape in order to understand the conditions under which the regulation of abortion provider facilities impact the existing market and barriers to entry.

Who seeks abortions?

According to the Guttmacher Institute, a policy and research institute that seeks to advance sexual and reproductive health, about one-third of women experiencing an unintended pregnancy in the United States will terminate their pregnancy, amounting to over 1.2 million abortions in 2008.⁹ As Figure C1 depicts, thirty-six percent of women seeking abortions are

non-Hispanic white women, 30% are non-Hispanic black women, 25% are Hispanic women, and 9% are other

Figure C1: Demographics of patients in the U.S. who obtained abortions in 2008



racess. Forty-two percent of women obtaining abortions have incomes below the federal poverty level and 27% have incomes between 100-199% of the federal poverty level (between

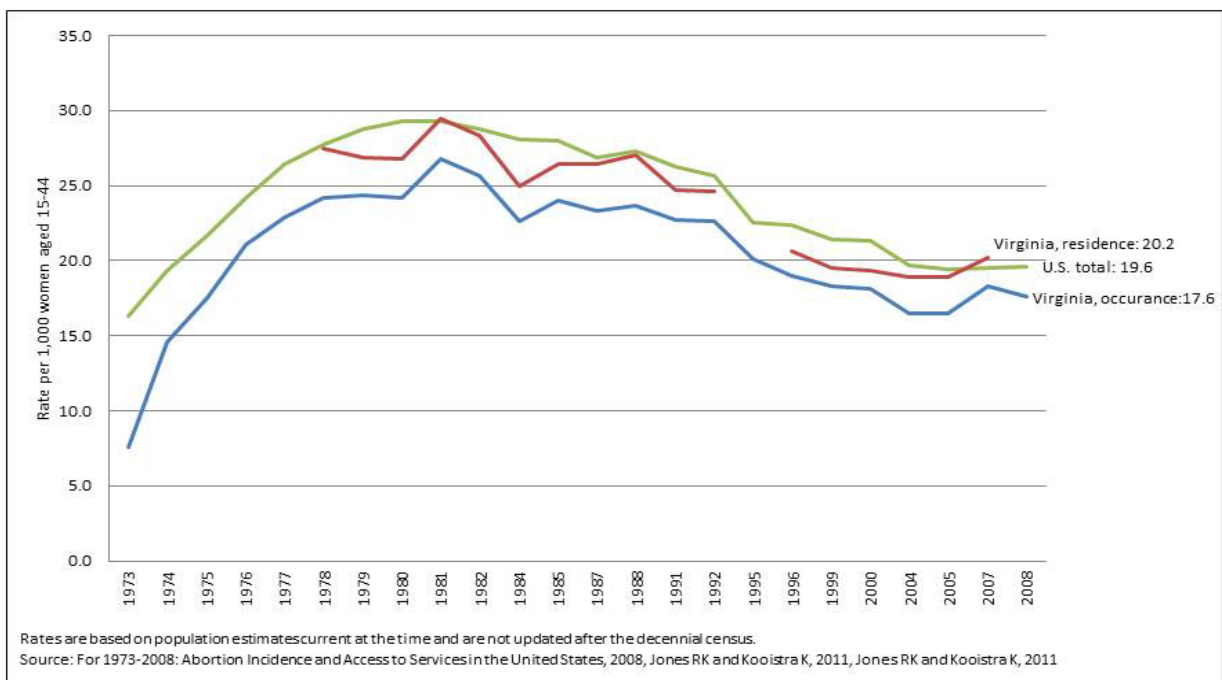
⁹Guttmacher Institute accessed 3-5-13. <http://www.guttmacher.org/datacenter/profiles/US.jsp>

\$22,050 and \$43,880 for a family of four). Data is not available for the demographics of patients seeking abortion in Virginia.

Virginia abortion rates have been consistently under those of the total U.S. population: 17.6 per 1,000 pregnancies in Virginia as opposed to 19.6 nationwide in 2008 (Figure C2). However, if the abortion rate is calculated by state of residence, Virginians sought an increasing number of abortions from 2005 to 2007, indicating that patients have increasingly been leaving the state to obtain abortions elsewhere.

David Nova of Planned Parenthood Health Systems explains that because it is illegal in Virginia to provide an abortion after the first trimester outside of a hospital, a patient can either choose a procedure at three times the cost in a hospital that provides second trimester abortions or travel outside the state. Patients can obtain second-trimester abortions at less than half the

Figure C2: Abortion rate in the U.S and in Virginia by state of residence and occurrence, 1973-2008



cost of a hospital in Virginia in a doctor’s office in Maryland, North Carolina, West Virginia and the District of Columbia. In Virginia, over ninety-eight percent of abortions in which the last menstrual period (LMP) was known occurred in the first trimester (see Figure C3). Nova estimates that, assuming the national Guttmacher data is consistent for Virginia residents, more than 80% of Virginia women seeking abortion after the first trimester receive care from medical facilities beyond the Virginia border.

Figure C3: Number of abortions among Virginia residents with known gestational ages (2011)

| Length of Gestation from Last Menstrual Period (LMP) | Number | Percentage of Total |
|--|---------|---------------------|
| Total for Virginia Residents with reported LMP | 23,479* | 100.0% |
| Under 14 Weeks (First Trimester) | 23,110 | 98.4% |
| 14 Weeks thru 19 Weeks | 283 | 1.2% |
| 20 Weeks and Over | 86 | 0.4% |

*In 2011, 156 of 23,635 abortions provided to Virginia residents lacked data for length of gestation.
 Source: VDH, Division of Vital Records
 Courtesy of David Nova, Planned Parenthood Health Systems

Which organizations provide abortions?

In 2008, there were 1,793 abortion providers in the United States, but they were not dispersed geographically: 87% of all counties lacked an abortion provider, while only 35% of women of childbearing age lived in those counties. Seventy percent of abortions were provided by specialized abortion clinics, 24% by non-specialized clinics, 4% by hospitals, and 1% by doctors’ offices (Jones, 2011). The Guttmacher Institute defines specialized abortion clinics as “non hospital facilities in which half or more of patient visits are for abortion services” and they can be non-profit, mission-driven organizations or private providers. However, according to prominent reproductive health researcher Dr. Rachel Jones, no data is available on the mix of non-profit vs. private providers. (R. Jones, personal communication, March 10, 2013).

In Virginia, these rates are more heavily weighted towards reproductive health centers, as Figure C4 depicts: 98.4% occur in specialized facilities/doctor’s offices and 1.6% occur in hospitals. The average cost to the patient varies from \$430 for a first trimester abortion to an average \$1562 for a second trimester abortion in a hospital.

Figure C4: Abortions in Virginia by facility type (2011) and cost to patient (2009)

| Facility type | Number* | % of Total | Average cost to patient (U.S.)** | Median cost to patient (U.S.)** |
|---|---------|------------|----------------------------------|---------------------------------|
| Abortions among all Medical Facilities | 23,635 | 100.00% | -- | -- |
| Reproductive Health Center / Physician’s Office | 23,254 | 98.40% | \$430 | \$425 |
| General Hospital | 381 | 1.60% | \$1562 | \$1500 |

*Source: VDH, Division of Vital Records, *Courtesy of David Nova, Planned Parenthood Health Systems*

**Source: Jones, R., Kooistra, K. (2011). Abortion incidence and access to services in the United States, 2008. *Perspectives on Sexual and Reproductive Health* 43 (1): 41-50.

Conditions in Virginia

As with all planning issues, it is crucial to understand the political climate and context that frames the issues around regulation. Virginia’s abortion regulations are no exception.

The General Assembly is the state legislature of Virginia. The General Assembly proposes and passes bills that become laws that are, in turn, operationalized via regulations, and created and administered by departments and boards comprised of members appointed by the governor. The power of the attorney general (AG) in Virginia is specific. According to AG Cuccinelli’s spokesperson and website, the AG “provides legal advice and representation to the Governor

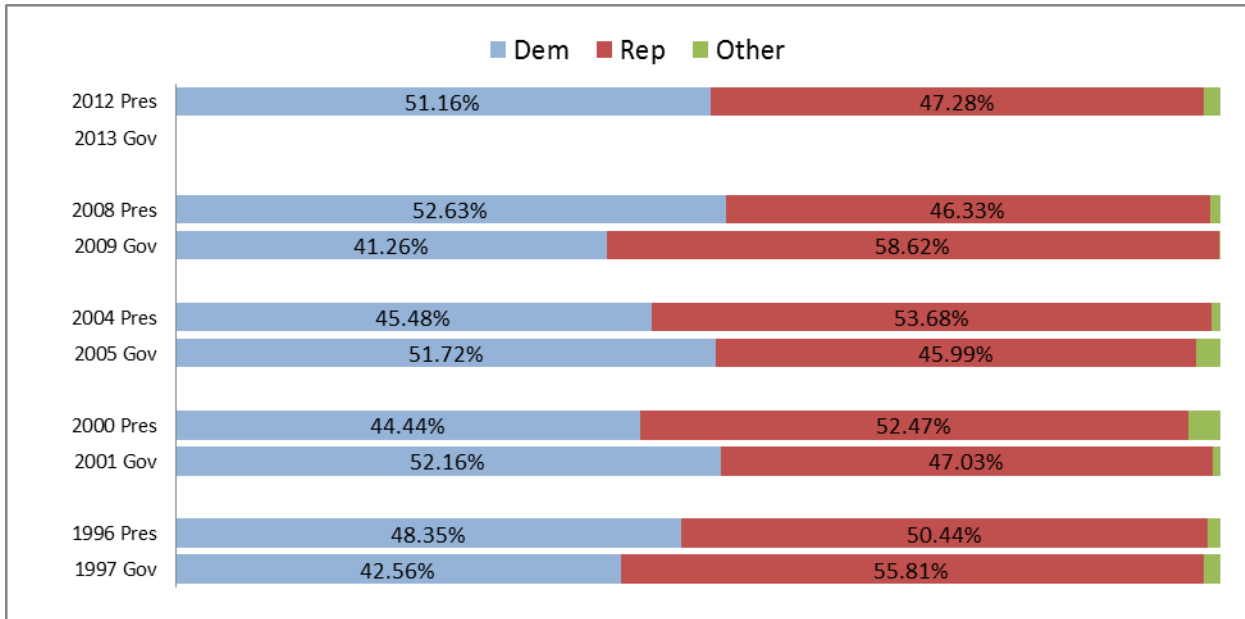
and executive agencies, state boards and commissions, and institutions of higher education.” The AG does not create law, but can make recommendations on regulation of state law to state boards (Sheppard, 2012; www.oag.state.va.us). Because it would be impossible to enforce all laws, all people in positions of enforcement are selective about the laws on which they focus. Cuccinelli is no exception; he has been very vocal about his position against abortion and about his intention to use regulation to make it less prevalent in Virginia.

In the case of health regulation, the General Assembly creates laws that the Department of Health operationalizes by way of regulations (as long as they do not conflict with constitutional limitations). The head of the Department of Health is the health commissioner, who is appointed by the governor. The Board of Health (the Board) also comprises 15 members appointed by the governor for four-year terms. The Board advises the governor and “makes, adopts, promulgates and enforces regulations, and provides for reasonable variances and exemptions there from, to carry out its responsibilities or those of the commissioner or the Department” (§32.1-12) (www.vdh.virginia.gov).

Virginia is considered a “purple” state, indicating that its population is politically heterogeneous. Figure C5 depicts presidential and gubernatorial election results for Virginia from 1996-2012. Virginians’ party favorite for president contradicted their gubernatorial selection two out of the previous four races. These results demonstrate that voting is not strictly along party lines. The fact that it is politically heterogeneous separates Virginia from most of the other states categorizing abortion providers as hospitals/ambulatory surgical facilities (ASF); Nine out of 15 states that categorize abortion providers as hospitals/ASF are considered staunch Republic

strongholds, which is typically correlated to anti-abortion views (Utah, Texas, Louisiana, Missouri, Mississippi, Tennessee, South Carolina, North Carolina, and South Dakota) (See Figure B1).

Figure C5: Presidential and gubernatorial elections results for Virginia from 1996-2012



Source: USA Election Atlas

By 1999, it was clear that the 2000 elections would have significant impacts on a number of abortion provider regulation issues. Providers feared that anti-choice Republicans would win both the House of Delegates and the Senate of Virginia, which would result in the passing of the hospital categorization for providers. While the House and Senate did become majority Republican that year, not all of the Republicans were willing to vote for the bill in 2000 and it did not pass.

The 2009 gubernatorial election marked a power shift for abortion opponents. For the first time in a decade, both the governor (Bob McDonnell-R) and the attorney general (Kenneth Cuccinelli-R) were openly and actively anti-choice and committed to using state regulation as a

vehicle to restrict access to abortion in order to reduce its prevalence. (Prior to his election as AG, Cuccinelli had attempted to get the regulation passed for eight years as a state senator). In 2011, the General Assembly passed emergency legislation regulating any facility providing at least five first-trimester abortions per month as a hospital (Senate Bill 924); Governor McDonnell subsequently signed the emergency legislation. Senator Ryan McDougle, the bill's sponsor, said the goal of the legislation was to, "make sure that all medical procedures are done in a safe manner and the regulations we'd expect are going to be ones that are similar to and no different from any outpatient procedures." (However, other outpatient procedures are not regulated similarly).

Because these were passed as emergency regulations, the public comment period typically required of new bills was curtailed and the bill took effect on January 1, 2012. Nova explains, "In June of [2012], the Board of Health met to amend and preliminarily vote on the final permanent regulations that would supersede the emergency regulations. These regulations, similar to the emergency regulations, included rules regarding infection control, inspections, safety procedures and other operational requirements. They also included architectural requirements pertaining to hallway width, room dimensions, covered entrances, parking spaces, air-quality control standards and other criteria typically reserved for new hospital construction." (D. Nova, personal communication, March 2013).

In June of 2012, the Board was made up of six members appointed by former Governor Kaine and nine appointed by Governor McDonnell. The board met to vote on the final permanent regulations. Included in the regulation that passed 6-5 was an amendment to exempt existing

facilities from the hospital regulation. Nova continues, “The members reasoned that retrofitting current health centers would be overly burdensome, if not impossible in some instances. Their decision was also influenced by the dearth of evidence that the architectural changes would have any appreciable positive effects on patient care or patient safety.” This type of amendment is also known as a “grandfather clause.”

Regardless of the Board’s justification and vote, AG Cuccinelli would not certify the version passed by the Board on the grounds that the grandfather clause was outside the scope of their responsibility. The Board was directed to re-vote in September 2012 without the grandfather clause.

In July of 2012, Governor McDonnell replaced board member Dr. Bhushan Padya (who had finished his term in June) with Dr. John Seeds, the chair of the OBGYN for Life organization and co-author of the 2011 regulations classifying abortion providers as hospitals.

On September 12, 2012, two days prior to the second vote, Senior Assistant AG sent a letter to the members of the Board reminding them that should a board member vote against the AG’s recommendation, they would not receive representation from the AG in the event that legal action was brought against the board members as a result of the regulation:

As is the case with any state entity represented by the Office of the Attorney General, Board members may refuse to follow the advice of the Attorney General. Should a Board member choose to disregard the Attorney General’s advice and subsequently be named in a lawsuit related to the particular Board action taken...the AG is not obligated to provide representation and it is within the discretion of the AG to decline both representation of the Board member and the appointment of special counsel. Such decisions are made on a case-by-case basis...” (Tysinger, A., Memorandum, 2012)

The Board subsequently voted 11-2 to uphold the regulation without the grandfather clause, despite Board member James Edmonson Jr.'s testimony about the flawed reasoning behind the regulations as written. Board member Anna Jeng argued that this would be the first time that the board subjected existing medical facilities to the standards meant for new buildings. But Senior Assistant Attorney General Allyson Tysinger told the board that because the licensing for abortion clinics is new, all facilities should be considered new. "This board has no authority to grandfather," she said at the meeting in September (Sheppard, 2012).

Board Chair Bruce Edwards, a Virginia Beach EMS chief, reported to a journalist that he and his fellow commissioners were acting within legal parameters when they signed off on the new regulations and that his vote to implement the new law had nothing to do with politics or his own beliefs—he was just doing as he was told by the Attorney General's office (Ingles, 2013). Attorney General Cuccinelli subsequently certified the regulation that went to the Governor for final approval.

After the second vote, Health Commissioner Dr. Karen Remley publicly denounced the regulation and the lack of a grandfather clause and stepped down from her appointment stating in a letter to colleagues that, "As you know, over the past year VDH has been developing and implementing regulations of all abortion facilities in Virginia. I have worked to guarantee the process of survey and licensure would be fairly and thoughtfully applied across the Commonwealth...Unfortunately, how specific sections of the Virginia Code pertaining to the development and enforcement of these regulations 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. I have submitted my resignation from the position from State Health Commissioner effective today.”

The repercussions of Dr. Remley’s resignation remain to be seen. I project that they will be significant since the health commissioner is responsible for reviewing and approving any applications for variance from the regulation (discussed below). Governor McDonnell appointed Dr. Cynthia Romero as Remley’s replacement, who does not have a public position on abortion. As Dr. Romero was appointed, Deputy Commissioner Dr. Maureen Dempsey gave notice of her resignation. Dr. Dempsey had been appointed by Dr. Remley and worked closely with her. Though she did not publicly comment on the reason for her departure, one can speculate that it was related to Dr. Romero’s appointment based on the sequence of events.

Providers have two years from initial licensure to come into compliance with the hospital regulation and have been engaged in the process since the spring of 2012, when they were inspected and given provisional licenses. Many are in the process of applying for temporary variances to Health Commissioner Romero’s office. The landscape may shift again this fall when Virginia elects a new governor: either Attorney General Cuccinelli or Democratic candidate Terry McAuliffe. The winner of the race will likely appoint a health commissioner aligned with his values on abortion and who will be responsible for variance requests. Should McAuliffe win, many abortion providers may stave off closure for the duration of his tenure.

The Regulation of Medical Procedures

Before the regulation that categorized abortion providers as hospitals, the Virginia Board of Health did not have guidelines for which procedures would be performed in which types of

facilities. Rather, Virginia followed the Facilities Guideline Institute's (FGI) *Guidelines for Design and Construction of Health Care Facilities* document that recommends that the type of facility needed be dictated by a procedure's level of required anesthesia. FGI is a non-profit dedicated to the promotion of consensus- and research-based guidelines for the construction of health facilities in the U.S.

Figure C6 demonstrates the relationship between the level of anesthesia and the size of the procedure room recommended by *The Guidelines*. Medical abortions do not require sedation and, accordingly, *The Guidelines* would not require they be performed in a surgical procedure room. First trimester surgical abortions are typically performed with regional anesthesia without pre-operative sedation and would thus be performed in a Class A surgical procedure room of 150 sq. ft. The regulations in Virginia that classify abortion providers as hospitals requires that all abortions, regardless of whether they are medical or surgical, be provided in a Class B surgical procedure room with a minimum of 250 sq. ft. of floor space. The Virginia Department of Health follows *The Guidelines* recommendations based on the level of anesthesia required for all procedures in Virginia except abortion.

Figure C6: FGI Guidelines 2010 recommendations for floor area required for procedures based on type of anesthesia used

| Class | Floor Area |
|---|---------------------------------|
| <p>Class A: performed</p> <ul style="list-style-type: none"> • Topical, local, or regional anesthesia without pre-operative sedation • <i>Excluded are intravenous, spinal, and epidural routes</i> | Clear floor area of 150 Sq. Ft. |
| <p>Class B:</p> <ul style="list-style-type: none"> • Provides for minor or major surgical procedures • Oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs | Clear floor area of 250 Sq. Ft. |
| <p>Class C:</p> <ul style="list-style-type: none"> • Provides for major surgical procedures • Require general or regional block anesthesia and support of vital bodily functions. | Clear floor area of 400 Sq. Ft. |

Source: Facilities Guideline Institute's (FGI) *Guidelines for Design and Construction of Health Care Facilities 2010*

Patient Safety, Variances, and Grandfather Clauses

Neither the Attorney General nor the Board of Health provided evidence of an impending health crisis or even a threat to patient safety based on current abortion provider practices. Opponents of abortion site “over 80 violations of the health code” as evidence that providers are dangers to public health, though they fail to explain that these include violations such as medical records stored improperly in cleaning supply closets. According to Dr. William Harp, Executive Director of the Board of Medicine, abortions account for approximately 1-2 disciplinary cases per year (out of about 26,000), whereas in 2010 there were 10 doctor disciplinary cases against plastic surgeons in Virginia for 9,100 procedures (Martz & Nolan, 2011). This amounts to 15 times more disciplinary cases brought against plastic surgeons than abortion providers. The Center for Disease Control cites that the risk of death from a legal early abortion is about .6 in 100,000 cases, whereas the risk of death associated with a tonsillectomy

is 3 per 100,000 (or five times higher risk of fatality).¹⁰ In Virginia a dentist in a doctor's office provides tonsillectomy. There is no regulation or licensure for dentists in Virginia.

Additionally, the fact that the regulation is only triggered when five or more abortions are provided per month indicates that there is not a health crisis due to abortion provision. If ensuring patient safety was central to the regulation, the regulation would not be triggered by a certain number of abortions performed; it would be required of any abortion.

The results of initial inspections conducted at each facility in Spring 2012 provide further evidence that abortion in Virginia has been safe and did not pose an impending public health threat. Tarina Keene of NARAL Virginia explains, "all Virginia providers [were granted] unconditional licenses as a result of the inspections by the Department of Health...An unconditional rating from VDH means that there are no safety concerns...Each provider got their preliminary licenses for the first year [after which they would need to comply with the physical specifications within two years]" (Menendez, 2013). Because plastic surgeons and dentists are not classified in the same manner, they are not subject to licensing or inspections.

Finally, the fact that the regulation includes a provision for variances indicates that the Board of Health lacks evidence of an impending health crisis or even a threat to patient safety based on current abortion provider practices. When there is an impending health crisis, no variances are granted. However, the regulation provides for a temporary variance (as opposed to a permanent variance). Regulation of other facilities includes the authority for the health

¹⁰ <http://www.americanwomensservices.com/faq/complications.php>. Accessed 4-5-13.

commissioner to grant a permanent variance, provided that patient safety is not compromised. In addition, applications for the temporary variances must include documentation of how facilities will come into compliance with the regulation.

The variance application instructions state: “The Office of Licensure and Certification will make a recommendation to the State Health Commissioner to either approve or deny the requested temporary variance based on its consideration of the following factors....[Including] whether the facility has an acceptable plan in place that addresses the long term compliance with the specific regulation to which a temporary variance is sought.” The implication of this is that providers will be required, without exception, to come into compliance with the regulation or be forced to discontinue abortion services.

An example of a provider in Virginia in which a variance is sought is the Blacksburg, Virginia Health Center of Planned Parenthood Health Systems. The Blacksburg facility only provides first-trimester medical abortions in which a patient is given the first of two medications in a doctor’s office, the second of which the patient takes at home. Documents submitted by the facility to the Board of Health (and obtained through a Freedom of Information Act request) explain that, “Medical abortion is a non-surgical process, in which the patient takes oral medications; there is no “procedure” and no sedation or anesthesia...Essentially, the patient has an ultrasound and a physical examination, and then is given an oral medication by the physician, and additional oral medication to take at home...Blacksburg does not have any treatment rooms; rather because of the nature of the services provided, Blacksburg has exam

rooms [akin to those in a doctor's office]." Under the regulation as written Blacksburg would need to renovate their facility or move to a new facility with surgical rooms of 250 sq. ft. (among other requirements) to administer the oral medication.

Though the Blacksburg facility has applied for a variance, the decision will largely ride on who the health commissioner is when it is reviewed. In November of 2013 a new Governor will be elected who is likely to appoint a new Health Commissioner whose views align with the winner's views on abortion. The candidates include Attorney General Cuccinelli, a vocal opponent of abortion and the driving force behind the hospital categorization, or Terry McAuliffe, a supporter of abortion rights. The administrators at the Blacksburg facility declined to comment on the temporary variance application citing that the delicate and volatile nature of the subject required confidentiality.

A grandfather clause is typically used in regulation to protect the rights of an existing facility or constituency provided there is not a threat to public health. For example, if a new regulation requires medical facilities to provide a certain number of parking spots for each procedure room, it may also exempt existing facilities on which the requirement would create a burden since this provision would not have an adverse impact on patient safety or health. (In the event that a regulation is directly related to patient safety, there may be a transition period, but not a grandfather clause). By way of comparison, Pennsylvania has also implemented significant regulations for abortion facilities, but has included grandfather clauses for existing facilities.

Further evidence that the regulation's lack of grandfather clause is incongruent with Virginia precedence includes the 2006 Board-certified regulations for hospitals, nursing homes, and outpatient surgical facilities (without singling out abortion providers), which included a grandfather clause for existing facilities. According to the ACLU, there has not been another instance in which Virginia Board of Health has created or amended a regulation and not grandfathered in existing facilities (Guthrie-Gastañaga, 2012). Lastly, FGI's *2010 Guidelines for Design and Construction of Healthcare Facilities* explicitly state that all guidelines adopted by a state should apply only to new construction or new renovations (*Guidelines*, pg. 6).

Effects of Regulation on Providers

Though pro-choice organizations such as NARAL have claimed that the regulation could lead to the closure of anywhere from 15-20 of 20 existing non-hospital providers, they do not provide information as to which facilities may have to discontinue services. Follow-up interviews with providers and with pro-choice advocacy organizations did not yield information as to which providers would be forced to close. Perhaps this is because providers do not want to publicly single out facilities that are vulnerable during the two-year compliance period or perhaps they are uncertain as to the effects of the regulation on specific providers. The 2013 Gubernatorial election may impact the outcomes of the regulation as well. As mentioned above, if Democratic candidate Terry McAuliffe wins, he could potentially appoint a health commissioner who is sympathetic to the providers' challenges, re-write the regulation, or reverse the regulation. If AG Ken Cuccinelli wins the Governorship, it is certain that he will continue to

focus his efforts on creating and enforcing restrictions on abortion providers and he will make official appointments based on an anti-choice litmus test, as Governor Bob McDonnell has done.

According to an Economic Impact Analysis conducted by the Virginia Department of Planning and Budget, fifteen of the twenty-one Virginia providers reported that they would have to incur renovation costs between \$75,000-6,000,000 to comply with the regulations, assuming they were able to raise the funds (median cost = \$300,000). Three facilities would have to make minimal adjustments to comply.

Based on archival and legislative review and open-ended interviews, I created a decision matrix to project the possible outcomes of the regulation assuming that Attorney General Cuccinelli is elected Governor and the regulation remains in place as is (See Figure C7 for a summary of the results described below). Based on interviews with primary sources, three providers affiliated with Planned Parenthood own their facilities and will be able to comply with no/minimal renovations.

Of the seventeen remaining facilities that had more than minimal adjustments to make, I separated them into those which owned versus leased their facilities. David Nova of Planned Parenthood explained that this is an important distinction because, assuming that the landlord allowed the structural changes, it would be dangerous to invest in a leased facility because an anti-choice individual or organization could buy the building and terminate the provider's lease. I categorized the ten providers that lease their facility as "Relocate/shut down" because I do not have enough data to determine their likely outcomes.

Of the remaining seven facilities that were owned by the providers, four have either already made changes or are in the process of renovating to comply. The final three providers that own their facilities have significant/costly changes to make and would either have to invest in their current building or build another facility. Because I was not able to establish contact with these providers, I have categorized them as “Relocate/shut down.”

Figures C8 and C9A-B depict the current geospatial distribution of providers mapped over the density of the female population between the ages of 15-44 and the potential scenarios that can occur if providers in the “Relocate/shut down” category do not continue abortion services.

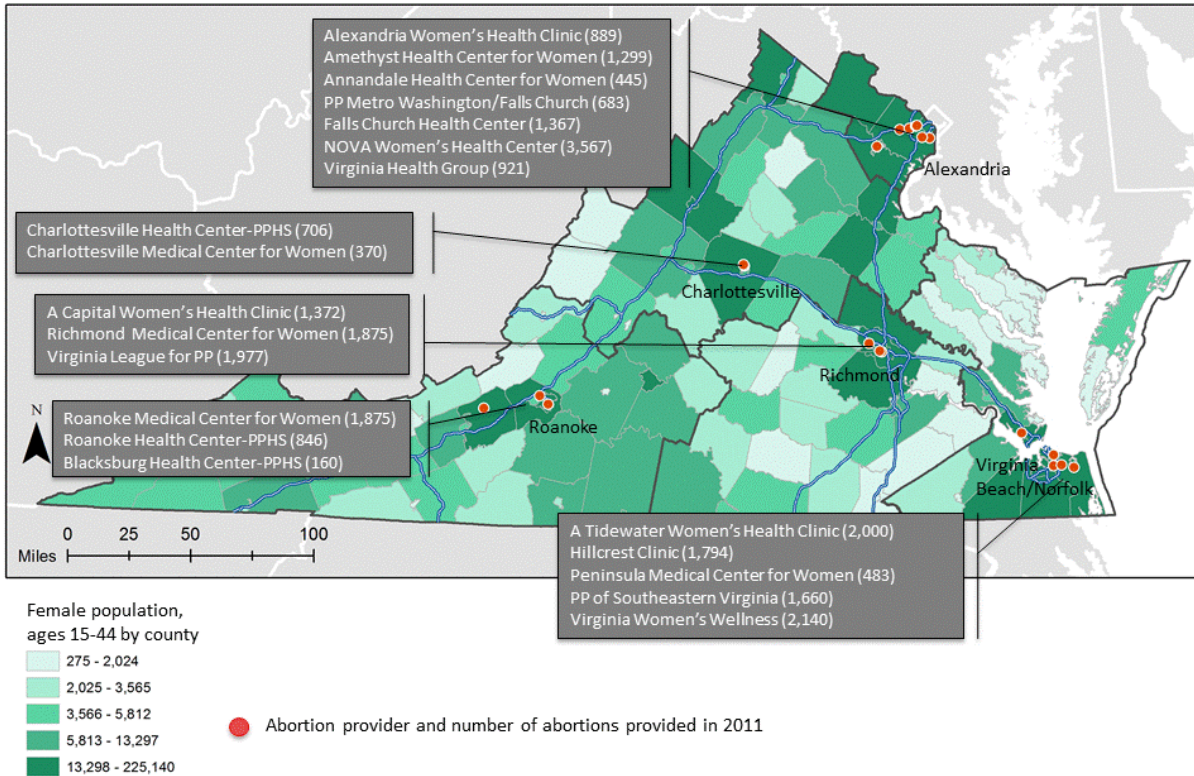
Figure C7: Projected effects of hospital categorization of abortion providers in Virginia*

| |
|--|
| No or minimal cost to comply |
| Own |
| Charlottesville Health Center- Planned Parenthood Health Systems |
| Planned Parenthood of Southeastern Virginia- Newtown Road |
| Roanoke Health Center- Planned Parenthood Health Systems |
| Relocate/shut down |
| Lease |
| Alexandria Women's Health Clinic |
| Amethyst Health Center for Women |
| Annandale Women & Family Center |
| Blacksburg Health Center- Planned Parenthood Health Systems |
| Falls Church Healthcare Center |
| Hillcrest Clinic |
| NOVA Women's Healthcare |
| Planned Parenthood Metro Washington- Falls Church |
| Virginia Health Group |
| Virginia Women's Wellness |
| Own |
| Charlottesville Medical Center for Women |
| Peninsula Medical Center for Women |
| Richmond Medical Center for Women |
| Will make/have made changes |
| Own |
| A Capital Women's Health Clinic |
| A Tidewater Women's Health Clinic |
| Roanoke Medical Center for Women |
| Virginia League for Planned Parenthood |

*Assuming that AG Ken Cuccinelli is elected Governor in 2013

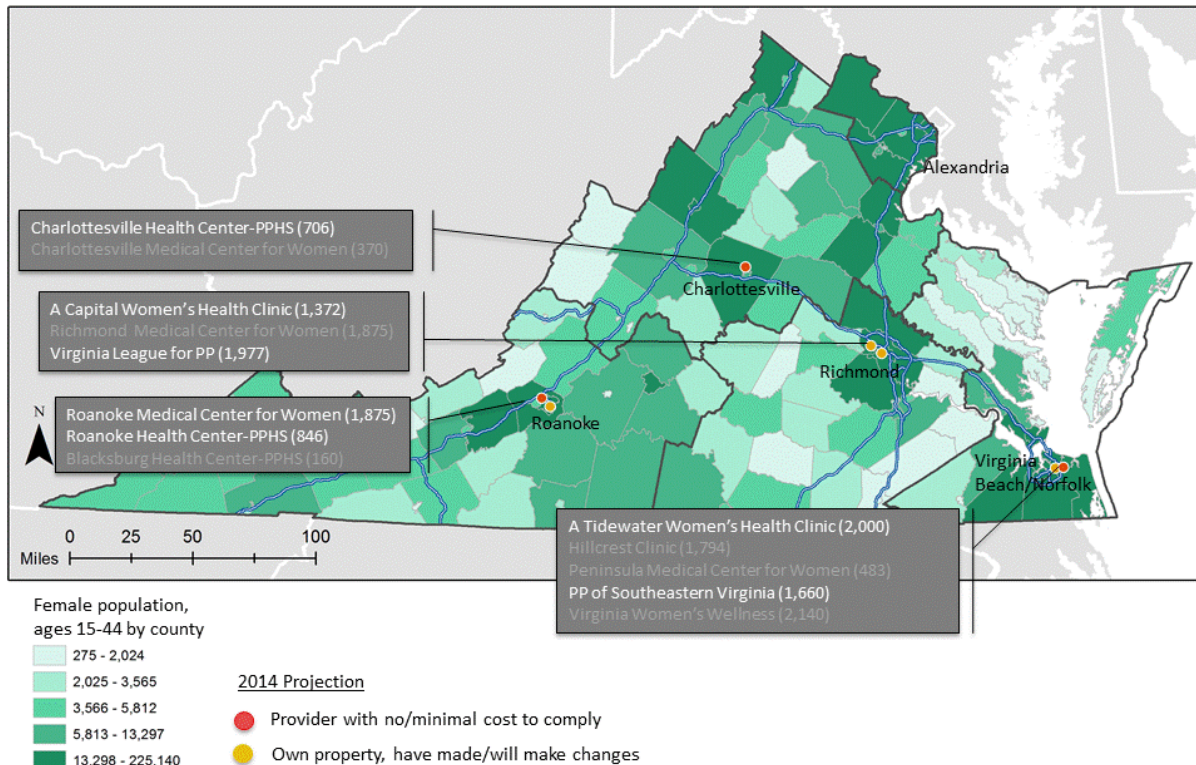
Policy and Politics: The effects of facility regulation on abortion access in Virginia

Figure C8: Existing abortion providers in Virginia (excluding hospitals) and number of abortions at each in 2011 and density of female population



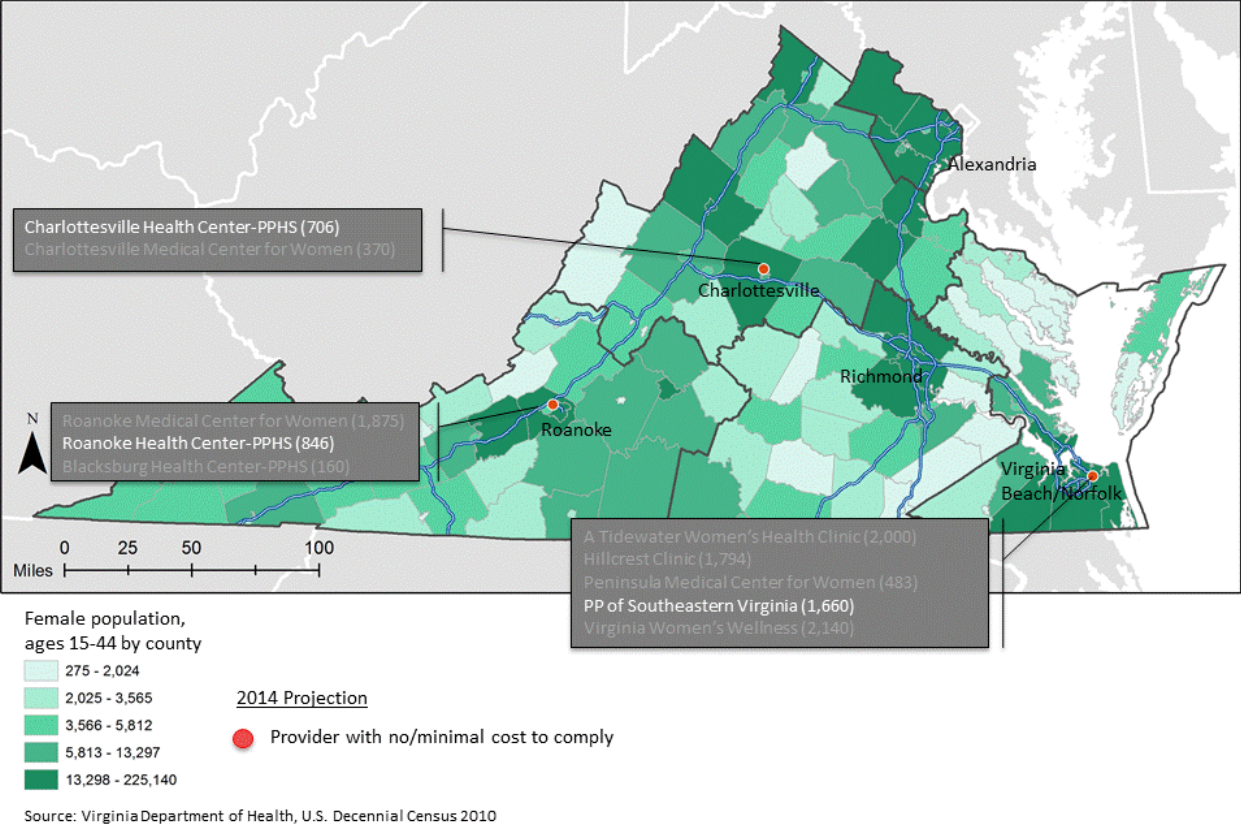
Source: Virginia Department of Health, U.S. Decennial Census 2010

Figure C9A: Providers with no/minimal cost to comply with hospital categorization and those who have or are making changes



Source: Virginia Department of Health, U.S. Decennial Census 2010

Figure C9B: Providers with no/minimal cost to comply with hospital categorization



Barriers to Entry for New Providers

Virginia is one of 36 states which has a form of certificate of public need (COPN) or certificate of need (CON) program.¹¹ Any medical organization seeking to make a capital investment in a facility must apply to the program within the Department of Health for approval. The COPN program acts as a gatekeeper for all new facilities and renovations that trigger a set of thresholds, including the amount of financial investment in the proposed changes or new construction. Thus, any health providers seeking to build a facility that would comply with the hospital regulation of abortion providers would need to apply for a COPN. Because of influence

¹¹ Virginia uses the term Certificate of Public Need (COPN) but this term can be used interchangeably with Certificate of Need (CON). Throughout this thesis, I will refer to the COPN, though the federal government uses CON.

that local politics and individual stakeholders can have on the application process (detailed below), new providers will likely face extensive opposition in the communities in which they seek to build.

The idea of a certificate of public need (COPN) or certificate of need (CON) for health facilities dates back to the 1960s and was federally established in 1974 by the Health Planning and Resource Development Act.¹² COPN is based on a statistical model called *Roemer's Law* that “demonstrated a positive association between the availability and the use of hospital beds. Roemer argued that available, unused beds put pressure on physicians to fill them; it follows that a hospital area with ‘too many’ beds will tend to induce ‘too much’ use” (Brown, 1983). The certification process would allow states to make determinations of an area’s need for a facility based on current providers’ capacities.

Peter Boswell, acting director of the Virginia Department of Health (VHD) COPN Program, emphasizes that the program is important because the 3rd party payer system distorts the market and makes normal market forces ineffective. One way that this is corrected is through the charity case conditions of the COPN. In Virginia, each COPN is issued based on the condition that the facility will provide a pre-determined level of charity care each year, not including Medicaid. He notes that in 2011, facilities provided \$857 million in charity care in Virginia, though he concedes that he can’t prove how much of it would not have been provided without the conditions. A facility's charity care level is calculated based on the regional average

¹² The Health Planning and Resource Development Act did not require COPN programs, but states without established COPN programs by 1978 would face decrease in federal Medicaid funding. All states save Louisiana complied (Choudhry 2005).

of charity care provided by existing facilities within the applicant's health region (Boswell, personal correspondence, 2013).

According to Virginia's COPN program website, the "program seeks to contain healthcare costs while ensuring financial viability and access to healthcare for all Virginia at a reasonable cost." It does so by issuing COPN based on the following criteria: (i) the relationship of the project to the long term health care state plan, (ii) the need for enhanced facilities to serve the population of an area, (iii) the extent to which the project is accessible to all residents in the proposed area and the immediate economic impact and financial feasibility of the project.

In Virginia, the process of COPN application begins with a letter of intent and application fee of 1% of the proposed capital expenditure (up to \$20,000). Once the COPN administrator has deemed the application complete, a 190-day review cycle begins which consists of regional health planning meetings including a public meeting and the opportunity for the applicant to respond to concerns raised through the process. In addition, "an informal fact-finding conference shall be held when (i) determined necessary by the department, or (ii) requested by any person seeking to be made a party to the case for good cause." This includes existing local health facilities as well as special interest groups; individuals also have standing to comment. The guidelines very clearly state that "any person affected by a proposed project under review may directly submit written opinions, data and other information to the appropriate regional health planning agency and the commissioner for consideration prior to their final action."

Inherent in the criteria and process are the institutional dynamics and political ideology of elected and appointed officials involved in health planning and any institutions with interests in the healthcare market. It stands to reason then that when decision-makers are biased against abortion provision, as many are publicly and vociferously in Virginia, that COPN would not be issued to new health organizations seeking to provide abortions. However, David Nova of the Roanoke Health Center-Planned Parenthood disagrees. He feels that with the support of local hospitals, an institution such as his could obtain a COPN. But the condition on his assumption is critical-- *if* the local hospitals would not only abstain from opposing the abortion provider, but publicly support it, *then* COPN *might* be awarded. This is an example of a state regulation that is subject to extremely local politics of adjacent institutions and local residents. The scope of the area in question can vary as well. In a metropolitan area such as Charlottesville, the unit of analysis may be the city boundaries, whereas in a more rural setting, institutions at a much greater distance may have standing in VDH's decision of whether to award certification.

Thus, there are two main barriers to entry for new providers: The cost of purchasing land and building a facility which complies with the hospital categorization and the COPN process, which is influenced by local actors including other healthcare providers, special-interest organizations and individuals.

An example of this is the Virginia Beach Health Center- Planned Parenthood's (VBHC) application for COPN in the winter of 2011 to renovate its facility. Anti-choice organizations came out in full force against the COPN application, which initially included two operating

rooms. After the first application was denied, the health center re-applied to add only one operating room. Then Health Commissioner Dr. Karen Remley (who resigned in October 2012 as discussed above) granted the COPN in March 2012. Any future applications for COPN will be subject to the same review and, as such, will depend largely on the appointed Health Commissioner at the time of application. This is another example of how political appointments can be used to emphasize or de-emphasize regulation based on personal ideology.

Comparable Procedures

In 2010, Brian Gottstein, Attorney General Ken Cuccinelli's spokesman, was quoted in the Washington Post saying, "There is no reason to hold facilities providing abortion services to any lesser standard for their patients. Even pharmacies, funeral homes, and veterinary clinics are regulated by the state." Gottstein fails to mention that Virginia does not regulate doctors' offices in which surgical procedures are provided. Before the regulation, health centers providing abortion services fell into the same classification as other physicians' offices that offer outpatient surgeries, such as colonoscopies, dental and cosmetic procedures.

Discussion

Virginia is an example of a state in which elected and appointed officials have used regulations of the provision of abortion to decrease access to abortions. Specifically, the regulation categorizing abortion providers as hospitals without an exemption for existing facilities will cause providers to reallocate resources in attempts to comply with building codes. These

building codes, as recommended by the non-profit Facilities Guidelines Institute, outline specific, purposeful, and evidence-based guidelines for hospital construction that are aimed at making them safer and more efficient. However, health centers providing reproductive health services including abortions do not operate under the same conditions as hospitals, nor have they demonstrated significant complication rates to warrant increased regulation and oversight. More complicated procedures such as dental surgeries and plastic surgeries remain unregulated in Virginia and can be performed in doctors' offices.

Elected official's emphasis on the regulation of abortion providers is not based on the need to improve safety conditions for patients. Rather, it is based on creating conditions under which providers will no longer be able to operate and new providers will not be able to enter the market. The reductions in providers in Virginia will disproportionately impact women with low incomes and little-to-no social supports because they have the most difficulty obtaining funds for abortion services, traveling to providers, and spending time away from child care or work responsibilities to do so. Because research has demonstrated that a reduction in supply of providers does not impact the demand for abortion after conception, these women will delay safe abortions or seek dangerous alternatives when faced with significant obstacles due to regulations. As they delay abortion, the procedure becomes more costly and more complicated, increasing the obstacles that women with low incomes must overcome. Women with access to financial resources will more easily travel longer distances, sometimes to other states, to obtain abortions.

Currently, the governance and power structure in Virginia does not allow for a system of checks and balances. Elected officials, such as the governor and attorney general, have appointed the health commissioner and the members of the board of health using their views on abortion as a litmus test. By doing so, their personal convictions and ideology have clouded their role as public servants and debilitated the ability of health planners to enable safe provision of health services to Virginians.

How should abortion providers be regulated?

With respect to the normative question of what a state's health department's role should be in regulating abortion, we must look to the regulation of all medical procedures. Just as Virginia and other states can use a Certificate of Public Need program to protect existing healthcare providers, and thus, patients, by regulating market entry, states must use regulation as a tool to create safe health care facilities that serve the public. As needed, regulations should be applied equally to all healthcare providers as necessary to maintain public safety, not just those that provide abortions. Prior to the hospital categorization, the Virginia Department of Health regulated procedures by the level of anesthesia used, as recommended by the Facilities Guidelines Institute, not by the type of procedure. Most states also use this method to regulate healthcare delivery to great success.

The American Health Planning Association's core values are access, quality, community participation, and collaborative planning. Central to their mission is the belief that, "Government is obligated to exercise sound stewardship of the public's resources, much of which it controls as the primary payer of services. Healthcare is a social good like safety and

education, which, in a democratic society, requires intelligent government oversight in order to balance competing needs and priorities.

What do the projections indicate?

As discussed in the Findings Section, my projections indicate that a provider's status as a non-profit or doctor's office, whether it owns or leases the facility, and its affiliation with a larger organization will impact whether or not a provider will be able to comply with the hospital categorization. As Figure C9 indicates, there are only three providers in Virginia that need to make few or no adjustments to their facility in order to comply with the hospital categorization. All three facilities are owned by the providers and all part of with Planned Parenthood Health Systems and affiliated Planned Parenthood Federation of America. In these cases, it seems to be the strength of, support from, and brand recognition of the parent organization that has enabled facility administrators to invest and advocate for forward-looking strategies that protect them from onerous regulations such as the hospital categorization. Both the Roanoke and Charlottesville Health Centers of Planned Parenthood Health Systems were built specifically to withstand the categorization, should it come into effect. The Planned Parenthood of Southeastern Virginia facility acquired a COPN in 2012 in order to add a surgical suite that would allow for compliance in the event that the regulation passed.¹³ However, if these and other regulations are able to decrease the diversity of providers such that Planned Parenthood-affiliated providers are the only ones left, opponents of abortion will be left with a bigger target on which to focus their fervor.

¹³ The Health Commissioner at the time was Dr. Karen Remley who later resigned as a result of the exclusion of the grandfather clause.

As with any market, diversification is the answer. The current reproductive healthcare market includes a variety of providers that came into existence based on the need of patients at various income levels and locations. However, it is not the role of the Virginia Health Department or any other state agency to *create* opportunities for different types of organizations to enter the marketplace. Instead, their role is to *encourage and allow for* diversification by focusing on the minimum regulations necessary to ensure safe service delivery.

Also, diversification of services offered by providers may shield them from the financial instability and uncertainty caused by targeted regulations. Most providers already offer an array of women's health services including birth control and cancer screenings. In fact, abortions are often not the primary service offered even if that is what the provider is primarily known for. By adding additional services, even those unrelated to reproductive health, providers can generate business that can support, or cross-subsidize abortion services, making the provider more resilient to the political ebbs and flows that effect regulation of this procedure.

Limitations

A limitation of this analysis and projection is that providers are assessed as comparable units. It assumes that any one provider will be able to absorb the demand for abortions that cannot be met by facilities that reduce capacity or stop providing abortions due to the increase in cost.

Future Research

Future research could assess the actual impacts on providers and patients, once the regulation fully takes effect in 2014 (after the two year compliance period). I would want to build a study that used survey data about the distance traveled to obtain abortion services, delays incurred, the mode of transportation used, and the resources needed to travel to a provider. Respondents would also be asked what, if any, obstacles they encountered in obtaining and abortion. This study would not be limited to Virginia as there is already evidence that patients travel outside the state to obtain abortions. In addition, it would be important to assess whether there is a reduction in demand for the abortions based on the regulation (even though research has consistently shown that abortion is an inelastic good).

Appendix A: Interviews

Jennifer Sandman
Senior Staff Attorney
Planned Parenthood Federation of America
November 2012

Tina Robilotto
Director, Consortium of Abortion Providers
Planned Parenthood Federation of America
November 2012

Vice Dean Gillian Metzger
Columbia Law School
December 2012

David Nova
Director of Strategic Initiatives at Planned
Parenthood Health Systems
Planned Parenthood
January 2013

Douglas Erickson
CEO
Facilities Guidelines Institute
January 2013

Bonnie Scott Jones
Special Counsel
Center for Reproductive Rights
January 2013

Ann Scott-Blouin
Executive Vice President, Customer
Relations
The Joint Commission
January 2013

Gail Frances, NP
Founder
Annandale Women & Family Health Center
January 2013

Peter Boswell
Acting Director
COPN Program
Virginia Department of Health
February 2013

Kelly Bishop
Health Center Assistant
Planned Parenthood
Charlottesville, VA
February 2013

David Nova
Director of Strategic Initiatives
Planned Parenthood Health Systems
Roanoke, Virginia
February 2013

Rachel Jones, PhD
Guttmacher Institute
Ongoing electronic correspondence
March 2013

David Nova
Director of Strategic Initiatives
Planned Parenthood Health Systems
Ongoing electronic correspondence
February-April 2013

Peter Boswell
Acting Director
COPN Program
Ongoing electronic correspondence
February 2013

Appendix B: Interviews requested but not granted

Paulette McElwain
Richmond Health Center- Planned
Parenthood

Olivia Gans
Virginia Society for Human Life

Victoria Cobb
Executive Director
Family Foundation

Delores Cousins
Board of Health Professionals, Department
of Medicine
Virginia Department of Health

Tarina Keene
NARAL Virginia

Jim Nolan
Correspondent
Times Dispatch

Kathy Greenier
ACLU Virginia

Linda Riddle
Facilities Coordinator
Planned Parenthood Health Systems

Erik Bodin
Director of Licensure and Certification
Virginia Department of Health

General Email
Coalition for Women's Health

Jill Abby
Richmond Medical Center

Office of Attorney General Cuccinelli

Frederick Kyle
Office of Licensure and Certification
Virginia Department of Health

Office of Governor Bob McDonnell

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