THE PENNSYLVANIA STATE UNIVERSITY
SCHREYER HONORS COLLEGE

DEPARTMENT OF POLITICAL SCIENCE

TARGETED REGULATION OF ABORTION PROVIDER LAWS: HOW BURDENSOME RESTRICTIONS IMPACT ABORTION ACCESSIBILITY

ERICA REEVES
SPRING 2018

A thesis
submitted in partial fulfillment
of the requirements
for baccalaureate degrees
in Political Science and Communication Arts and Sciences
with honors in Political Science

Reviewed and approved* by the following:

Erin Heidt-Forsythe
Assistant Professor of Women's, Gender, and Sexuality Studies and Political Science
Thesis Supervisor

Michael Berkman
Professor of Political Science
Honors Adviser

* Signatures are on file in the Schreyer Honors College.

ABSTRACT

After the legalization of abortion on the federal level in 1973, states have scrambled to retain control over women's access to abortion. One way state governments have succeeded in limiting accessibility is through the enactment of Targeted Regulation of Abortion Provider laws (TRAP laws). These laws specifically target providers of abortion, with the expressed intent to make the procedure safer, but with the underlying goal to make accessibility more difficult and even shut down clinics. This thesis addresses how states with TRAP laws differ in abortion accessibility from those which do not have TRAP laws. Accessibility, for the purpose of this thesis, is operationalized as abortion rate, number of abortion clinics, and percent of counties within a state that have no clinics. This paper also analyzes how the number and type of TRAP laws impact the components of abortion accessibility. This study shows the negative impact that TRAP laws can have on the percent of counties within a state that have no clinics, how the number of TRAP law implemented can negatively impact the percent of counties within a state that have no clinics, and how the party control of state government impacts accessibility. Another important result was the negative impact of poverty levels on accessibility.

The findings of this thesis show how the burdensome restrictions of TRAP laws can lead to a decline of accessibility for women. TRAP laws are becoming increasingly widespread yet are being passed under false pretenses. While proponents of these laws claim the restrictions need to be enacted in order to make facilities safer for women, their true effect is limiting abortion access.

TABLE OF CONTENTS

LIST OF TABLES

ACKNOWLEDGEMENTS

First and foremost, I would like to thank Professor Heidt-Forsythe for not only sparking the inspiration for this thesis, but also for her constant support and guidance through this process. I am so grateful to have worked with someone whose passion and knowledge for women's rights was able to guide this research in the right direction. I am so thankful for her unwavering confidence in my work and my vision. Thank you to Dr. Michael Berkman and Dr. Gretchen Casper for your helpful insight and wisdom that helped me to develop this project. As always, I would like to thank my loving parents, sister, and friends who have given me their incredible support when I needed it most.

Chapter 1

Introduction

Since the historic *Roe v. Wade* decision in 1973 which legalized abortion at the federal level, states have taken it upon themselves to limit abortion accessibility through various forms of regulation. A subset of these abortion laws target abortion clinics specifically, known as Targeted Regulation of Abortion Provider laws, also known as TRAP laws. While all abortion regulations involve abortion clinics, these laws specifically target the physicians' offices and buildings where the procedure is physically performed, as well as the space outside the building such as the lawn and driveway by setting regulations on requirements for the physical plant and admitting privileges with hospitals (Guttmacher Institute 2018). These laws are significant because they can lead to abortion clinics closing as a result of noncompliance with the burdensome regulations, which limits abortion access to women all over the United States. While abortion is technically legal, it is not accessible to all women because of the decreasing number of abortion providers and subsequently, abortion clinics. TRAP laws may place an undue burden on abortion clinics, leading to noncompliance and/or forcing the clinic to shut down because of financial costs or impossibly high standards.

Past research has focused on only one type of TRAP law, a single U.S. state, or an individual clinic. These studies have focused on the enactment of TRAP laws (Medoff & Dennis 2011), how general abortion laws impact the number of clinics (Medoff 2009), and TRAP laws' constitutionality (Greenier & Glenberg 2014). What is lacking in existing literature is a

quantitative analysis of states with and without TRAP laws, and the effect of these laws on abortion accessibility.

How does abortion accessibility vary state to state as a result of state Targeted Regulation of Abortion Providers (TRAP) laws? To answer this question and because this data had not previously been compiled all in one place., I created an original dataset of which states have TRAP laws for all fifty states for the years 2008 to 2018. I coded for whether a state had a TRAP law and if they did, what category the law or laws fell into. The seven different TRAP laws I coded for are: structural standards comparable to those for surgical centers, procedure room size specification, corridor width specification, maximum distance to hospital specification, transfer agreement with hospital requirement, hospital privileges, and hospital privileges or an alternative agreement. This allowed me to test the relationship between TRAP laws and abortion accessibility. This research can remedy the hole in the existing literature by looking at how TRAP laws implemented by states impact the number of abortion clinics, abortion rate, and percent of counties without clinics on a nationwide scale. My main hypothesis is that a state with TRAP laws will have fewer abortion clinics, a lower abortion rate, and a higher percentage of counties without clinics when compared to states without TRAP laws. The other hypothesis is that states with multiple TRAP laws will have less clinics and a lower abortion rate than those with just one law. These laws impose an undue burden on abortion providers, leading to clinics closing as a result of noncompliance.

The Guttmacher Institute has provided data on the number and type of TRAP laws per state beginning in 2013 and NARAL Pro-Choice America has published state level data on TRAP laws since 2008. These two main data sources have allowed me to compile a dataset of each state and their corresponding TRAP laws.

This study concludes with a discussion of the findings and how the research may serve as a tool for people to inform themselves with and lawmakers to reference when making decisions about abortion regulations. This study implies that TRAP laws serve the purpose of closing clinics and are successful at it, instead of protecting women's health.

Chapter 2

Literature Review

While abortion policy is a hot topic in today's politics, its implementation dates back to the early to mid-nineteenth century. During this time, "most Americans believed that the fetus was imbued with a soul at the time of 'quickening,' or when the pregnant woman first felt the fetus move, which is generally at about eighteen-week gestation," (Rose 2007). Before quickening, not even the Catholic Church acknowledged that a human life existed and abortion was not considered a crime before ensoulment (when a fetus "got" a soul). As time progressed, so did abortion restrictions. America passed its first official abortion regulation in 1821 in Connecticut. This law made it illegal for women to have a poison induced abortion after the fourth month of pregnancy (Chicago Tribune 2008). In 1857 the American Medical Association pushed to make abortion illegal and by 1873 the Comstock Law was passed. This law banned obscene material, including the distribution of material which could be used for abortion or birth control (Caron 2012). According to this regulation, any non-physician provider of abortion was a criminal (Luker 1984).

During the next century, multiple laws were passed to continue the restriction of abortion. During the early twentieth century, states passed "midwife bans" that allowed only physicians to perform abortions. State-level abortion bans were so prevalent that every state had one. Then, in the 1940s, women could be put on trial for obtaining an illegal abortion instead of just the abortion providers (Rose 2007). At this point in time, the only legal way to obtain an abortion was from the approval of doctors or a hospital board. In the 1950s, therapeutic abortion boards

that required women to get the approval from a board of professionals before she could obtain an abortion were established (Luker 1984). A restriction of access throughout the 20th century drove women to seek out illegal abortions, which for many women could have negative health consequences or result in death.

The biggest legal upheaval came on January 22, 1973 with the landmark *Roe v. Wade* decision. "Roe overturned nearly all state abortion regulations existing at the time and expanded the fundamental right of privacy established earlier in *Griswold v. Connecticut* (1965) to include abortion," (Rose 2007). Right after the decision was made, state attempts at strict regulations were shot down by lower courts. Thus, TRAP laws were born, framing their regulations to be for women's health and not to strictly limit accessibility. According to the Guttmacher Institute, since the *Roe v. Wade* decision, states have enacted more than 1,074 laws to limit access to the procedure. While abortion was mandated to be legal at the federal level, states have stepped up to get in the way of the procedure in a variety of ways.

Targeted Regulation of Abortion Provider laws were a direct result of this need to limit abortion access at the state level. This is because while states could not outlaw abortion completely, they had the power to make the process of obtaining an abortion very difficult. These laws target the abortion clinic itself with state-mandated regulations. *Planned Parenthood v. Casey* further allowed for these laws to be adopted through the June 29, 1992 decision. *"Planned Parenthood of Southeastern Pennsylvania v. Casey (1992),* rejected abortion as a fundamental right and lowered the standard of review to "undue burden" (Kreitzer, R., 44-45). Undue burden is present when the regulation presents a substantial obstacle for women who are trying to obtain an abortion (Corley 2016). I argue this concept of "undue burdens" allowed a proliferation of TRAP laws, leading to the closing of clinics. This is because the new standard

for undue burden shifts the burden of proof to women and physicians and is also very vague, giving little guidance to lower courts (Benshoof, J. 1993).

By definition, TRAP laws place regulations specifically on abortion providers that are more restrictive than those on similar medical practices (Medoff and Dennis 2011)," (Kreitzer, R., 45). These laws emerged as a result of states implementing regulations to further restrict access to abortion services. Unlike other abortion laws, TRAP laws impose stringent restrictions on *providers,* requiring them to make unnecessary and expensive changes to facilities and staff (Mercier 2016). Instead of just making the process of obtaining an abortion more difficult or longer, these laws can lead to clinic shutting down as a result of noncompliance with regulations. The changes required by these laws can be extremely expensive structural modifications that are impossible to comply with. Also, forcing a provider to be within certain mileage of a hospital can mean the end of providers in rural areas because they can't just pick up and move their clinic to the nearest town or city (Center for Reproductive Rights 2015, Guttmacher 2018, Planned Parenthood 2018). Compliance with such restrictions are not only medically unnecessary, but also are not imposed upon other similar medical facilities. Thus, this places an undue burden on providers. This results in less options when seeking out an abortion and can make it impossible for women of lower income to afford to travel to a clinic if ones in her area have been shut down as a result of TRAP laws. Therefore, TRAP laws lead to lower abortion accessibility.

There are several different types of TRAP laws which states can implement. Many of these laws include structural requirements for abortion clinics. These can include mandating corridor width, room sizes, and even janitor closet dimensions. A different type of TRAP law is admitting privileges, which requires providers to be able to admit a patient to a nearby hospital (Planned Parenthood 2018). Another type of law which requires providers to have a relationship

with hospitals is the law which mandates that a clinic can't exceed a specified maximum distance to a hospital (Guttmacher Institute 2018).

These laws came into the spotlight of the abortion debate when, in 2013, Texas required providers to have admitting privileges at a local hospital and have structural standards comparable to ambulatory surgical centers. These laws were challenged in the Supreme Court case of *Whole Woman's Health v. Hellerstedt* where both laws were found to place an undue burden on abortion providers and concluded that "the restrictions failed to offer medical benefits sufficient to justify the burden on access," (Reingold & Gostin 2016). The 5 to 3 majority decision was made on June 27, 2016. The decision is extremely important because it not only overturned these categories of TRAP laws in Texas, but now requires that other states prove that the burden they are placing on abortion providers is backed by consideration of women's health. The TRAP laws in Texas are unconstitutional because the requirements are so hard to meet that petitioners argued that they would cause many clinics to close (Greasley, K. 2017). This case impacts all abortion regulations because it established that no abortion regulation can have the effect of imposing an undue burden (Reingold & Gostin 2016).

There are multiple variables which may impact Targeted Regulation of Abortion Provider law implementation. Partisanship, religiosity, and public opinion can impact whether or not a state passes abortion regulations. Republican control, percent of the population that is Catholic and where the public's opinion falls on the abortion debate have all been documented as determinants of the emergence of TRAP laws in previous research. Marshall H. Medoff and Christopher Dennis (2011) conducted a study to see exactly what factors contributed to the emergence of TRAP laws. They performed a qualitative, historical analysis to discern which factors were determinants of the enactment of a TRAP law by states during the time period of

1974 to 2008. This study found that Republican institutional control of a state's legislative and executive branches is positively associated with a state enacting a TRAP law, whereas Democratic control is negatively associated. Medoff and Dennis' study also concluded that the percentage of a state's population that is Catholic, public anti-abortion attitudes, state political ideology, and the abortion rate in a state are all statically insignificant predictors of a state enacting a TRAP law. Even though the abortion rate and political ideology are insignificant predictors of TRAP law enactment, I included them because I'm not examining their enactment, but rather how these variables might impact accessibility.

TRAP laws reflect trends of abortion restriction laws at the state level. These laws reflect the strategies of anti-abortion movement in the U.S. "Opponents of abortion adopted a strategy of "legal but inaccessible" that has resulted in the passage of more than 700 state laws since the early 1990s," (Kreitzer, R., 41). TRAP laws are particularly good at making abortion "legal" yet "unavailable" because these laws are unreasonably burdensome and expensive for clinics to comply with. Compliance with new clinic regulations in Virginia during 2013 would cost up to $1 million per clinic, according to the Virginia Department of Health (Guttmacher Institute 2018). Noncompliance with these laws can lead to the closing of clinics, resulting in an increase of the number of women experiencing delays in obtaining their abortion (Guttmacher Institute 2018). Abortion may still be a legal procedure, but if women have trouble obtaining one then it becomes an inaccessible procedure. According to Rose's *Safe, Legal and Unavailable* (2007), "there seems to be no relationship between the number of abortions performed and its legal status: women have abortions, regardless of whether they are legal or not" (Rose 2007 pg. 28). Regardless of legality, women will have abortions. Clinics need to be kept open so that when a woman does have an abortion, it is in a safe and medically appropriate environment. TRAP law

proponents argue that the purpose of these laws is to protect women's health and safety, yet the reality is that they are jeopardizing women's ability to have a safe abortion (Mercier 2016).

The public's opinion when it comes to abortion ranges across a spectrum of pro-abortion rights and anti-abortion rights. Pro-abortion right believers lean towards maintaining that abortion should be legal and accessible to all women, whereas anti-abortion right supporter believe that abortions should either be illegal altogether or only legal under extreme circumstances, such as incest or rape. Taking a stance on the abortion debate can be very personal for individuals, making it next to impossible to get people to change their opinions. Public opinion on abortion is important because abortion policy responds to public opinion, (Kreitzer 2015).

Partisanship can have a defining impact on abortion policy. According to a study done by Rebecca Kreitzer in 2015, "Abortion policies are shaped through representation, by the gender and partisanship of state legislators," (Kreitzer, R., 42). Additionally, her study concluded that constituent values and partisan factors both explain specifically *anti-abortion* policies. It also concluded that "unified partisan control of the state legislature and party of the executive are significant predictors of abortion policy," (Kreitzer, R., 58). It has also been found that "Republican institutional control of a state's legislative/executive branches is positively associated with a state enacting a TRAP law," (Medoff and Dennis, 951), which means that more Republican control can lead to more restrictions on abortion policies.

Targeted Regulation of Abortion Provider laws can also impact public health. The emotional burdens and increased workload that TRAP laws place on providers is a public health threat (Mercier, Buchbinder, and Bryant 2016). TRAP laws can also delay an abortion procedure, leading to a public health threat. If clinics close as a result of a TRAP law, a woman

might not have a clinic readily available to them and might have to travel a long distance for the procedure. This potential for delay is a public health threat because abortions later in the gestational period are riskier (Mercier, Buchbinder, and Bryant 2016). Additionally, if women cannot afford to travel to a clinic in a further geographic location, they may turn to unsafe abortion options. Access to quality health care is an indicator of national public health, so abortion accessibility is integral to safety around abortion (Jones and Weitz 2009). TRAP laws can lead to lower abortion accessibility, which in turn impacts public health.

Abortion laws in general impact abortion providers. Mercier, Buchbinder, Bryant and Britton (2015) examined this impact in another study in which they focused on a single state. Instead of taking the more traditional route of abortion research and focus on how these laws impact women, they decided to view it through a different lens and see the impact these laws had on abortion providers during the time period of 2011 to 2015. After conducting 31 interviews of abortion providers, including physicians, nurses, physician assistants, counselors, and clinic administrators within the abortion clinics in North Carolina, this study found trends where abortion providers viewed abortion laws which appear to target women in a very negative light and that clinics had to consistently adapt their practice to meet the requirements of this category of law. An example of this was a counseling law where abortion providers had to read their patients material which spoke about the fetus as an unborn baby who feels pain. The providers felt that requirements such as this made the patients feel as though the providers were not on their side, and that providers were trying to convince patients to change their mind about their abortion decision. Overall, providers viewed these types of law as potentially harmful to patients and felt it was extremely difficult to comply with these laws and still provide comprehensive abortion care.

There has been research done on how these laws have impacted specific states and individual clinics, but scholarship has yet to examine states and compare how those without TRAP laws differ from states with TRAP laws across measures of abortion accessibility. In this study, accessibility is measured by abortion rate, the number of abortion clinics, and the percent of counties without abortion clinics. The number of abortion clinics, abortion rate, and percent of counties without clinics have to be impacted by the presence of lack of TRAP laws in each state. My research will take the study of TRAP laws across all of the states where the impact will be looked at over time, adding something that is completely lacking in previous research in the field.

Chapter 3

Data and Methodology

As previous research on TRAP laws has been mostly qualitatively focused (Medoff, M. and Dennis, C. 2011, Mercier, Buchbinder, Bryant and Britton 2015), a quantitative study was needed to provide insight on Targeted Regulation of Abortion Providers Laws and their impact on abortion accessibility for women. A quantitative study was also needed to empirically show the impact of TRAP laws on accessibility over time. In order to show this, I chose to run a regression for my quantitative analysis. My unit of analysis is all 50 states and my time frame is 2008 until 2018. It is important to looks at TRAP laws over time because it can show how an increase in the enactment of these laws over time impacts accessibility.

A yearly, state level database of TRAP laws does not exist, so I created an original dataset from 2008 until 2018 of all 50 states and their TRAP laws, from data published by the Guttmacher Institute and NARAL Pro-Choice America. The dataset includes all fifty states from the year 2008 to 2018 and whether or not they have a TRAP law in place. Additionally, this dataset includes the categories of TRAP laws each state has from 2013 to 2018.

My independent variable of Targeted Regulation of Abortion Providers is coded as a dummy variable. I coded 1 if the state had a TRAP law during the given year and 0 if there was no TRAP law. I then went on to code for seven different categories of TRAP laws: structural standards comparable to those for surgical centers, procedure room size specification, corridor width specification, maximum distance to hospital specification, transfer agreement with hospital requirement, hospital privileges, and hospital privileges or an alternative agreement.

Table 1: TRAP Law Categories and Descriptions

Table 1: TRAP Law Categories and Descriptions	
Categories	**Descriptions**
Structural Standards Comparable to Those for Surgical Centers	Mandates all abortion providers comply with the same building requirement as those for ambulatory surgical centers; 1 = presence of law, 0 = absence of law
Procedure Room Size Specification	Structural requirement which regulates the size of the room in which an abortion is performed; 1 = presence of law, 0 = absence of law
Corridor Width Specification	Structural requirement which specifies the hall width; 1 = presence of law, 0 = absence of law
Maximum Distance to Hospital Specification	Requires an abortion facility is within a specified distance to a hospital; 1 = presence of law, 0 = absence of law
Transfer Agreement with Hospital Requirement	Requires an agreement between a facility and hospital in order to transfer patients if procedural complications arise; 1 = presence of law, 0 = absence of law
Hospital Privileges	Requires the providers to have admitting privileges at a hospital; 1 = presence of law, 0 = absence of law
Hospital Privileges or an Alternative Agreement	Requires the providers to have admitting privileges at a hospital or be in affiliation with a physician who does; 1 = presence of law, 0 = absence of law

The Guttmacher Institute has published which states have TRAP laws and the type of TRAP laws enacted from 2013 until 2018. This allowed for me to have complete data for those years. This was also coded as a dummy variable, 1 being coded if a state had a requirement in each of the seven categories and a 0 if the state did not. NARAL Pro-Choice America has published a *Who Decides? The Status of Women's Reproductive Right in the United States* series with data going back until 2008. While this allowed for me to code whether or not a state has a TRAP law during the years 2008 until 2012, it did not allow me to code these years for the seven categories of types of TRAP laws. In order to keep consistency for coding TRAP laws, states were only coded a 1 for a TRAP law if the laws "subject abortion providers to burdensome restrictions not applied to other medical professionals," (*Who Decides?*), not if the law only "prohibits certain qualified health care professionals from performing abortions," (*Who Decides?*) because the Guttmacher Institute data does not account for this.

The dependent variable of this study is abortion accessibility, which is operationalized as the abortion rate per 1,000 women aged 15 to 44 years by state of occurrence, number of abortion clinics per state, and the percentage of counties within a state without abortion clinics. I broke abortion accessibility down into these three categories because I think they accurately reflect different components of accessibility. The abortion rate was coded as the percentage number gathered from the Henry J. Kaiser Family Foundation and the Center for Disease Control (CDC) Abortion Surveillance Reports. The abortion rate is the rate of legal abortions per 1,000 women aged 15 to 44 years old by state of occurrence. I took the raw data from the CDC and if there was missing information, I supplemented with the information from the Kaiser Family Foundation for the years 2008 to 2014.

The number of abortion clinics per state is not published for the public to use for every year, so I compiled a full set of data for 2017 by using *Safe Place Project's* compilation of abortion clinics per state for that year. The years 2008, 2011, and 2014 were coded using data from two publications of *Abortion Incidence and Service Availability in the United States* (Jones, R. K., & Jerman, J. 2014, 2017). I chose to focus on abortion clinics over abortion providers in general because they may be a better indicator of accessibility (Jones and Jerman, 2014). The final component of abortion accessibility is percentage of counties within a state without abortion clinics. This was coded as the percentage number taken from NARAL Pro-Choice *Who Decides? The Status of Women's Reproductive Right in the United States* series.

I controlled for legislative control of each state by looking at the state control of each state and coding for either Democratic, Republican, or divided control. This data came from the National Conference of State Legislatures (NCSL) for years 2009 to 2018. I also controlled for poverty levels per state. This was a percentage of the total population of the state that was in poverty. I coded this as the percentage of those in poverty using data from the United States Census Bureau.

Chapter 4

Results and Analysis

The results of these regressions provide great insight into the impact of Targeted Regulation of Abortion Provider laws on abortion accessibility. Running a regression allowed me to consider the impact that these laws had on multiple variables. Although the data on the number of abortion clinics per state is incomplete, I break down the percent change per year to show their decline over time. The primary findings include the negative impact that TRAP laws can have on the percent of counties within a state that have no clinics, how the number of TRAP laws implemented can negatively impact the percent of counties within a state that have no clinics, and how the party control of state government impacts accessibility. Another important result was the impact of poverty levels on accessibility.

The first test was run to see the impact that TRAP laws had on a state's abortion accessibility. This was done to see whether or not a state with a TRAP law differed from a state without any TRAP laws. The results of this analysis are in Table 2. The first primary finding of this study is the negative impact that TRAP laws can have on the percent of counties within a state that has no abortion clinics. My results show that states with TRAP laws present tend to have a higher percent of counties without abortion clinics. This means that states with these regulations implemented have lower accessibility in the form of having more counties without a single clinic present in them. Having a high percentage of counties without a single abortion clinic present can make it difficult for women in rural areas to access abortion resources because

they may have to travel long distances to reach the nearest clinic. It can also make it financially difficult for women of lower socioeconomic status to access abortion clinics if they have to pay to travel outside of their own county. Even though these findings were not significant, I think this would be a great area for future research if more detailed information on TRAP laws becomes available for public use over a longer period of time.

Table 2: Effect of TRAP laws on Accessibility

Table 2: Effect of TRAP laws on Accessibility

	Abortion Accessibility		
Predictors	**Number of Abortion Clinics**	**Abortion Rate Per 1,000 Women**	**Percent of Counties Without Clinics**
TRAP Law	3.887	1.742**	1.625
Divided Government	-16.945**	-2.451***	17.589***
Republican Government	-19.925***	-4.132***	25.437***
Poverty Levels	1.041	-0.367***	2.314***
Constant	12.061	18.298***	27.839***
Standard Deviations	26.151	4.908	18.564
R-squared	0.085	0.147	0.374
Adjusted R-squared	0.045	0.134	0.368
No. observations	98	272	390

Note: *p<0.1; **p<0.05; ***p<0.01

The main finding of my study was the impact that party control of a state has on abortion accessibility. The finding that was most interesting was how Republican control of a state government impacted abortion accessibility. If a state government was Republican, then it tended to have a lower number of abortion clinics, a lower abortion rate per 1,000 women, and a higher percent of counties without an abortion clinic. Marshall H. Medoff and Christopher Dennis (2011) had conducted a study that found that a state with Republican control of the legislative and executive branches was positively correlated with the implementation of a TRAP law. This could explain why abortion accessibility is lower in Republican controlled states. The Republican Party also has an outwardly known anti-abortion ideology, which could also result in the enactment of other abortion laws other than TRAP laws. This ideology drives political goals and leads to lower abortion accessibility across the board.

Another significant finding related to party control was the impact that a divided state government had on abortion accessibility. If a state government is divided, the number of abortion clinics in that state tends to be lower, the abortion rate tends to be lower, and the percent of counties without abortion clinics is much higher. Having a divided state government not only negatively impacts abortion accessibility in general, but also has a negative impact on it in all three categories. The negative impact is slightly lower than that of Republican control, but still significantly has an impact on accessibility. A divided government might have a negative impact on access because it could be difficult to reverse any abortion restrictions that were already in place.

A third significant result of my first regression analysis is the influence that poverty levels of a state has on abortion accessibility. The two significant results were the impact poverty levels had on the abortion rate and percentage of counties in a state without any abortion clinics.

If a state had a higher level of poverty, then it tended to have a lower abortion rate per 1,000 women and a higher percentage of counties without any abortion clinics.

This regression also had a significant result that I was not anticipating. According to this regression, TRAP laws are correlated with increasing abortion rates. One thing that could have contributed to this unexpected result is that some states without TRAP laws have other abortion laws which dissuade women from obtaining an abortion. If some states without TRAP laws have different laws which limit accessibility, then their abortion rate would also be lower and potentially impact the regression result.

My second regression was run to see the impact that states with multiple TRAP laws had on abortion accessibility. This variable was called TRAP strength, so the more TRAP laws a state had enacted then the higher TRAP strength that it had. The results of this analysis are in Table 3. Although the relationship between multiple TRAP laws and the abortion rate per 1,000 women was not statistically significant, it is positively associated with the percent of counties without clinics at the $p<.1$ level. This result showed that as the number of TRAP laws a state has increases, so does the percent of counties without any abortion clinics. I think that as the number of TRAP laws a state has goes up, so does the burdensome impact that it has on abortion clinics. As a result of the TRAP laws, clinics have more regulations to comply with. This could result in the closure of clinics who are unable to meet sometimes impossible standards. For this regression, another interesting result was that a divided state government was even more likely than a Republican state government to have a lower number of abortion clinics.

Table 3: Effect of Number of TRAP laws on Accessibility

Table 3: Effect of Number of TRAP laws on Accessibility

	Abortion Accessibility		
Predictors	**Number of Abortion Clinics**	**Abortion Rate Per 1,000 Women**	**Percent of Counties Without Clinics**
TRAP Strength	0.257	0.003	1.618*
Divided Government	-21.080*	-4.147***	20.767***
Republican Government	-19.904*	-4.519***	27.555***
Poverty Levels	1.618	0.002	1.956***
Constant	6.559	14.370***	30.299***
Standard Deviation	27.254	5.137	17.265
R-squared	0.116	0.143	0.438
Adjusted R-squared	0.026	0.101	0.438
No. observations	44	85	171

Note: *p<0.1; **p<0.05; ***p<0.01

In order to show that the number of abortion clinics has decreased over time, I calculated the percent change in the number of abortion clinics over time. I wanted to show that there had been a decrease in abortion accessibility in the form of less clinics nationwide. While I was not able to have complete data for the number of abortion clinics per state for every year, the data that I did obtain was very insightful. I calculated the percent change between the subsequent years that I had complete data for and also the total percent change from 2008 until 2017. This shows a steady decrease in the total number of abortion clinics over time and a dramatic decrease

overall. While these are not anywhere near statistical results, I believe that this decrease in clinics is a real indicator of a reduction of abortion accessibility. The less clinics there are, the less options women have for obtaining an abortion. Women may be forced to travel long distances if the clinic in their area closes. When factoring in the cost of travel, some women may not be able to afford the procedure. Women in rural areas who do not have access to public transportation may be especially susceptible to limited abortion access as a result of clinics closing.

Table 4: Percent Change in Number of Abortion Clinics Over Time

Table 4: Percent Change in Number of Abortion Clinics Over Time				
	Change From 2008 to 2011	Change from 2011 to 2014	Change from 2014 to 2017	Total Change from 2008 to 2017
Total Change	-1.53%	-6.12%	-19.80%	-25.86%

Chapter 5

Conclusion

This study examines the impact that Targeted Regulation of Abortion Providers laws (TRAP laws), have on abortion accessibility. I was able to test this by creating my own data set for all 50 states from the year 2008 until 20018. My main hypothesis was that a state with TRAP laws will have fewer abortion clinics, a lower abortion rate, and a higher percentage of counties without clinics when compared to states without TRAP laws. The other hypothesis was that states with multiple TRAP laws will have less abortion clinics, a lower abortion rate than those with just one law, and a higher percentage of counties without clinics.

I found that states with TRAP laws present tended to have a higher percent of counties without abortion clinics. My results showed that if a state government was Republican, then it tended to have a lower number of abortion clinics, a lower abortion rate per 1,000 women, and a higher percent of counties without an abortion clinic and if a state government is divided, the number of abortion clinics in that state tends to be lower, the abortion rate tends to be lower, and the percent of counties without abortion clinics is much higher. The results also showed that if a state had a higher level of poverty, then it tended to have a lower abortion rate per 1,000 women and a higher percentage of counties without any abortion clinics. My second regression showed that as the number of TRAP laws a state has in the seven categories goes up, so does the percent of counties without any abortion clinics.

I did not anticipate finding that TRAP laws were positively correlated with a higher abortion rate. While I anticipated finding the opposite, I think that there were other factors that I

did not anticipate which led to this result. The presence of other abortion regulations in states may have impacted the abortion rate and therefore the results.

The data I compiled about the number of abortion clinics is an interesting addition to the conversation about abortion accessibility. While there was not enough information for statistical significance, this shows that there is in fact a dramatic decrease in the number of abortion clinics over time. I argue that this has to have an impact on the ease of abortion accessibility for certain women.

My study unfortunately had some limitations. I did not have complete data for the number of abortion clinics per state for every year, so it was hard to draw conclusions based on the limited amount of information available. If this data becomes available to the public and the timeline could be expanded, this would be a great addition future research.

Another limitation was the small amount information available regarding the types of TRAP laws. While I was able to have complete information for each state regarding whether or not they had a TRAP law in one of the seven categories for the years 2013 to 2018, this would have been much more comprehensive if I had this information going farther back.

Overall, the findings of this thesis show how the burdensome restrictions of TRAP laws can lead to a decline of abortion accessibility for women. The presence of multiple TRAP laws can lead to a high percentage of counties in a state without a single clinic. The research may allow people to see the true implications of the enactment of TRAP laws and how limiting women's access to safe and legal abortions can be detrimental to their health, not improve it.

BIBLIOGRAPHY

Benshoof, J. (1993). Planned parenthood v casey. the impact of the new undue burden standard on reproductive health care. *JAMA: The Journal of the American Medical Association, 269*(17), 2249-2257. doi:10.1001/jama.269.17.2249

Brackett, E. L. (2004-2005). Trapped: Greenville women's clinic v. commissioner, south carolina department of health and environmental control and the proliferation of targeted regulation of abortion providers. Southwestern University Law Review 34, 511-526. 511-526.Caron, S. Comstock Law. Vol. 1 2012.

Center for Reproductive Rights. "Targeted Regulation of Abortion Providers (TRAP)." *Center for Reproductive Rights*, 28 Aug. 2015, www.reproductiverights.org/project/targeted-regulation-of-abortion-providers-trap.

Chicago Tribune. "Timeline of Abortion Laws and Events." *Chicagotribune.com*, 12 July 2008, www.chicagotribune.com/sns-abortion-timeline-story.html.

Corley, P. C. (2016). Undue burden on women's right to seek an abortion: Whole woman's health v. hellerstedt (2016). *Justice System Journal, 37*(4), 385-2. 10.1080/0098261X.2016.1222188

Goodwin, M. (2017). Whole woman's health v. hellerstedt: The empirical case against trap laws. Medical Law Review, 25(2), 340.

Greasley, K. (2017). Taking abortion rights seriously: Whole woman's health v hellerstedt.*The Modern Law Review, 80*(2), 325-338. doi:10.1111/1468-2230.12256

Greenier, K. & Glenberg, R. (2014). Virginia's targeted regulations of abortion providers: The attempt to regulate abortion our of existence. Washington and Lee Law Review: 71(2), 1233-1261.

Guttmacher Institute (2018). Targeted regulation of abortion providers. Guttmacher Institute. Retrieved from https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers.

Jones, B. S., & Weitz, T. A. (2009). Legal barriers to second-trimester abortion provision and public health consequences. American Journal of Public Health, 99(4), 623-630. 10.2105/AJPH.2007.127530

Jones, R. K., & Jerman, J. (2014). Abortion incidence and service availability in the united states, 2011. *Perspectives on Sexual and Reproductive Health, 46*(1), 3-14. 10.1363/46e0414

Jones, R. K., & Jerman, J. (2017). Abortion incidence and service availability in the united states, 2014. *Perspectives on Sexual and Reproductive Health, 49*(1), 17-27. 10.1363/psrh.12015

Medoff, M. H. (2009). The relationship between state abortion policies and abortion providers. Gender Issues 26, 224.

Medoff, M. H., & Dennis C. (2011). TRAP abortion laws and partisan political party control of state government. American Journal of Economics and Sociology 70, 951-97

Mercier, R. J., Buchbinder, M., & Bryant, A. (2016). TRAP laws and the invisible labor of US abortion providers. Critical Public Health, 26(1), 77-87. 10.1080/09581596.2015.1077205

Mercier, R. J., Buchbinder, M., Bryant, A. & Britton L. (2015). The experiences and adaptations of abortion providers practicing under a new TRAP law: A qualitative study. Contraception 91(6), 507-512.

Norrander, B. & Wilcox C. (1999). Public opinion and policymaking in the states: The case of post-Roe abortion policy. Policy Studies Journal 27, 707-722.

Planned Parenthood. “TRAP Laws Are Dangerously Chipping Away at Abortion Access Under the Guise of 'Women's Health'.” *Planned Parenthood Action Fund*, Planned Parenthood, 2018, www.plannedparenthoodaction.org/issues/abortion/trap-laws.

Reingold, R. B., & Gostin, L. O. (2016). Women’s health and abortion rights: Whole Woman’s health v hellerstedt. *Jama, 316*(9), 925-926. 10.1001/jama.2016.11074

Rose, Melody. “Safe, Legal, and Unavailable?: Abortion Politics in the United States." Congressional Quarterly, 2007.

Who decides? the status of women's reproductive rights in the united states. (2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017). NARAL Pro-Choice America.

ACADEMIC VITA

ERICA N. REEVES

ericareeves95@aol.com

EDUCATION

The Pennsylvania State University **University Park, PA**
Schreyer Honors College
B.A. Political Science, B.A. Communication Arts and Sciences, Minor in Business of the Liberal Arts
Paterno Fellows Scholar

International Studies Institute **Florence, Italy**
Study Abroad Program *January 2017 – May 2017*

PROFESSIONAL EXPERIENCE

Georgetown Law Social Justice Fellowship **Washington, D.C.**
Legal Fellow *March 2016 – May 2016*
Worked closely with Georgetown Law professors and practicing attorneys to research and fully understand the societal implications of disability law. Instructed over 40 students in advanced Street Law classes on my research of disability law.

Giangrieco Law, P.C. **Montrose, PA**
Legal Intern *June 2014 – December 2016*
Finalized, typed, and proof-read legal documents such as pleadings, wills, deeds, briefs, and contracts. Conducted overhaul of over 7,000 case files to maximize organization and legal relevance for office use. Met with clients to schedule appointments, remind them of responsibilities and resolve communication issues with attorneys.

Pennsylvania State University Dissertation Research **State College, PA**
Research Assistant *June 2016 – August 2016*
Collected and electronically coded data related to subnational electoral outcomes and the partisan make-up of state legislatures.

Kohl's Corporation **Vestal, NY**
Managerial Intern *June 2017 – August 2017*
Analyzed promotional tactics and business trends to recommend strategic plans. Interviewed, hired and trained staff and served as Manager on Duty.

LEADERSHIP EXPERIENCE

Delta Sigma Pi Business Fraternity: Pledge Committee Project Director
Delta Sigma Pi Business Fraternity: Community Service Chair
Phi Sigma Pi Honors Fraternity: Alumni Chair

HONORS

Student Marshal of Communication Arts and Sciences *Spring 2018*