**Washington and Lee Law Review**

Volume 71 | Issue 2 Article 18

Spring 3-1-2014

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Katharine Greenier
*American Civil Liberties Union of Virginia*

Rebecca Glenberg
*American Civil Liberties Union of Virginia*

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Katharine Greenier*
Rebecca Glenberg**

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* Reproductive Freedom Project Director of the American Civil Liberties Union of Virginia.

** Legal Director of the American Civil Liberties Union of Virginia.

## *I. Introduction*

After forty years of providing safe, trusted reproductive health care, Hillcrest Clinic in Norfolk, Virginia, closed April 20, 2013.[1] The clinic, which opened in October 1973, just nine months after the Supreme Court decided *Roe* v. *Wade*,[2] was the first ever medical facility in South Hampton Roads to provide legal abortions.[3] A bomber, an arsonist, and an antichoice extremist firing two dozen bullets into the clinic could not close Hillcrest's doors.[4] What did? Burdensome, discriminatory government regulations that imposed requirements unrelated to patient safety only on doctor's offices and clinics providing first-trimester abortions.[5] The clinic's director, Suzette Caton, said that it would have cost the clinic $500,000 to install the new physical plant requirements, including new ventilation and temperature controls,[6] required by the rules, none of

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1. *Hillcrest Clinic*, NAT'L ABORTION FED'N, http://www.thehillcrest clinic.com (last visited Jan. 22, 2014) (on file with the Washington and Lee Law Review).

2. 410 U.S. 11 (1973).

3. Amy Jeter, *Norfolk Abortion Clinic Plans to Close Doors*, VIRGINIAN PILOT (Apr. 19, 2013), http://hamptonroads.com/2013/04/norfolk-abortion-clinic-plans-close-doors (last visited Jan 22, 2014) (on file with the Washington and Lee Law Review); *see also* Lori Adelman, *New TRAP Laws Force Virginia Abortion Clinic to Close After 40 Years of Service,* FEMINISTING (Apr. 22, 2013), http://feministing.com/2013/04/22/new-trap-laws-force-virginia-abortion-clinic-to-close-after-40-years-of-service/ (last visited Jan. 22, 2014) (arguing that TRAP laws were designed not to make abortions safer but rather to limit access to abortions in Virginia) (on file with the Washington and Lee Law Review).

4. *See* Jeter, *supra* note 3

> In 1983, a man broke in, poured kerosene throughout the office and set it ablaze. A year later, a cluster of pipe bombs exploded nearby, breaking a plate glass window of the bank branch on the first floor. In December 1994, Hillcrest made national news when John C. Salvi III opened fire on its building with a semi-automatic rifle a day after he'd killed two people and injured five at two clinics outside Boston.

5. *See* 12 VA. ADMIN. CODE §§ 5-412-10 to -370 (2013) (providing comprehensive regulation of first-trimester abortion facilities). The regulations discussed in this article impose restrictions on facilities performing abortions in the first trimester of pregnancy, the simplest and safest time to perform a surgical abortion. *See id.* § 5-412-10 (defining "abortion facility" as any facility in which five or more first trimester abortions are performed per month). Virginia law already requires second and third trimester abortions to be performed in a hospital. VA. CODE ANN. §§ 18.2-73, -74 (West 2009).

6. *See* Jeter, *supra* note 3 (noting that the Hillcrest Clinic closed its doors rather than comply with the costly regulations).

which were required to provide good medical care.[7] The onerous and unnecessary regulations Caton cited are called Targeted Regulations of Abortion Providers (TRAP).[8]

Antichoice movement leaders unable to ban abortion using lawsuits, intimidation, or, in some cases, violence have now turned to a strategy of seeking to regulate abortion providers out of existence, achieving indirectly what they couldn't accomplish directly, particularly with respect to first-trimester abortions, which enjoy the greatest protection under *Roe v. Wade*.[9] TRAP laws are one of the regulatory initiatives the purpose of which is to eliminate all access to legal abortions by making it physically or economically impossible for doctors and clinics to provide these services.[10]

TRAP laws require women's health centers that provide first-trimester abortions to follow more stringent regulations than other similar outpatient medical facilities.[11] One common TRAP law

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7. *See Norfolk Abortion Clinic Closing After 40 Years; Cites New State Regulations*, RICHMOND TIMES-DISPATCH (Apr. 19, 2013, 12:39 PM), http://www.timesdispatch.com/news/state-regional/norfolk-abortion-clinic-closing-after-years-cites-new-state-regulations/article_a9c09b58-a90f-11e2-af4c-0019bb30f31a.html (last updated Apr. 20, 2013, 10:31 AM) (last visited Jan. 22, 2014) (noting that the Hillcrest Clinic is the only abortion clinic in Virginia that is not attempting to renew its license) (on file with the Washington and Lee Law Review). The Times-Dispatch also notes these important factors in the clinic's decision to close: "Caton also says costs of supplies and staffing have increased. Meanwhile, the number of abortions at the clinic declined from 2,116 in 2009 to 1,629 [in 2012]." *Id.*

8. *See* 12 VA. ADMIN. CODE §§ 5-412-10 to -370 (2013) (providing comprehensive regulation of first-trimester abortion facilities).

9. *See* Roe v. Wade, 410 U.S. 113, 164 (1973) ("For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician."); *see also* Jeter, *supra* note 3 (describing the history of violence against the Hillcrest Clinic); Adelman, *supra* note 3 (arguing that TRAP laws were designed not to make abortions safer but rather to limit access to abortions in Virginia).

10. *See* Kate Sheppard, *Abortion Foe's Latest Backdoor Ban*, MOTHER JONES (June 27, 2011, 2:00 AM), http://www.motherjones.com/politics/2011/06/abortion-foes-latest-backdoor-ban (last visited Jan. 22, 2014) (arguing that TRAP laws, such as those in Virginia, are targeted specifically to close abortion clinics) (on file with Washington and Lee Law Review).

11. *See Targeted Regulation of Abortion Providers (TRAP): Avoiding the TRAP*, CENT. FOR REPROD. RTS. (Nov. 1, 2007), http://reproductiverights.org/en/document/targeted-regulation-of-abortion-providers-trap-avoiding-the-trap (last visited Jan. 22, 2014) [hereinafter *Avoiding the TRAP*] (discussing general requirements under TRAP laws across several states) (on file with

requires that women's health centers meet the standards of Ambulatory Surgical Centers (ASCs),[12] which perform outpatient procedures that are more invasive and more risky than abortion.[13] These regulations generally cannot be met by doctors' offices or outpatient clinics and go far beyond what evidence-based medical practice guidelines would require to assure quality care and patient safety.[14] By either forcing some centers to close because they cannot meet the new requirements or by driving up the cost of abortion procedures so much that some women can no longer afford them, TRAP laws make a woman's constitutional right to abortion illusory by imposing insurmountable obstacles on access to abortion.[15]

The right to decide whether and when to be a parent is essential to women's equality. As the Supreme Court noted, without the ability to control their reproductive lives, women cannot participate fully and equally in society.[16] In order to ensure women's equality, attempts to restrict reproductive rights must be seen for what they truly are—measures aimed, incrementally and state by state in a coordinated nationwide strategy, to make abortion legal in

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Washington and Lee Law Review).

12. *See* GUTTMACHER INST., STATE POLICIES IN BRIEF 1 (2013), http://www.guttmacher.org/statecenter/spibs/spib_TRAP.pdf (noting that twenty-six states currently require first-trimester abortion clinics to meet the standards for ASCs).

13. *See id.* (arguing that these requirements "do little to improve patient care but . . . set standards that may be impossible for providers to meet").

14. *See Avoiding the TRAP*, *supra* note 11 (noting that ten states currently require abortion clinics to be licensed as an ASC).

15. *See What Are TRAP Laws?*, VA. COAL. TO PROTECT WOMEN'S HEALTH, http://www.coalitionforwomenshealth.org/learn-more/trap-laws.shtml (last visited Jan. 22, 2014) ("There are no legitimate medical purposes for singling out abortion providers.") (on file with the Washington and Lee Law Review).

16. *See* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 856 (1992) ("The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives.").

name only by cutting off access to abortion procedures.[17] TRAP is one such strategy.[18]

First-trimester abortion is and should be seen as just one service among the full array of comprehensive women's health services.[19] Accordingly, abortion should be regulated, like any other medical procedure, based on accepted standards of care and evidence-based practice.[20] Abortion providers should be treated the same as other doctor's offices and outpatient medical facilities providing medically comparable services and procedures.[21]

Part II of this Article will discuss the emergence of TRAP in Virginia. Part III explains how flaws in the administrative process resulted in regulations that were contrary to the recommendation of health experts and regulators' own best judgment. Part IV explores how TRAP undermines the constitutional right to abortion. Part V discusses why the new regulations for women's health care centers in Virginia are unnecessary and unrelated to the health and safety of the patients those centers serve. Part VI will discusses the effect of TRAP in Virginia, particularly its impact on low-income women's

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17. *See* Amelia Thomson-Deveaux, *The Supply-Side Economics of Abortion*, THE AM. PROSPECT (Nov. 13, 2013), http://prospect.org/article/supply-side-economics-abortion (last visited Jan. 22, 2014) (arguing that after failing to curb the demand for abortion, antichoice advocates passed TRAP laws as a mechanism to cut off the supply of abortion) (on file with the Washington and Lee Law Review).

18. *See* Joerg Dreweke, *New Wave of Laws Seek to Shut Down Abortion Providers*, GUTTMACHER INST. (June 27, 2013), http://www.guttmacher.org/media/nr/2013/06/27/ (last visited Jan. 22, 2014) (describing TRAP laws as a "cynical ploy" to limit access to abortion) (on file with the Washington and Lee Law Review).

19. *See Avoiding the TRAP*, *supra* note 11 (arguing that TRAP laws harm women by limiting their reproductive and medical opportunities).

20. *See* Tamara Dietrich, *A Chainsaw to Va Abortion Rights*, DAILY PRESS (June 15, 2012), http://articles.dailypress.com/2012-06-15/news/dp-nws-tamara-clinics-0615-20120615_1_first-trimester-abortions-health-care-second-trimester-abortions (last visited Jan. 22, 2014) (quoting Dr. James Ferguson of the University of Virginia School of Medicine as saying the idea that medical regulation should be based on evidence and need was "lost" on the Virginia Legislature) (on file with the Washington and Lee Law Review).

21. *See Avoiding the TRAP*, *supra* note 11 (arguing that TRAP laws "target" abortion precisely because they regulate abortion more heavily than comparable medical services).

access to abortion. Part VII describes current litigation and advocacy efforts to overturn TRAP in Virginia.

## *II. The Emergence of TRAP in Virginia*

### *A. At the General Assembly*

TRAP took center stage in Virginia in 2011. Prior to 2011, the Virginia General Assembly considered but did not enact TRAP legislation.[22] Frequently, such bills originated in the House of Delegates but were killed in the Senate Committee on Education and Health.[23] The House's 2011 TRAP bill fit this pattern.[24] House Bill 1428, which would have required abortion clinics that conduct twenty-five or more abortions per year to meet the emergency equipment requirements of ASCs, failed in the Senate committee. [25] It was one of nine bills undermining a woman's right to make private reproductive health care decisions that failed in 2011.[26]

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22. *See generally* H.D. 114, 2004 Gen. Assemb., Reg. Sess. (Va. 2004); H.D. 116, 2004 Gen. Assemb., Reg. Sess. (Va. 2004); H.D. 479, 2004 Gen. Assemb., Reg. Sess. (Va. 2004); H.D. 1290, 2004 Gen. Assemb., Reg. Sess. (Va. 2004); H.D. 2347, 2005 Gen. Assemb., Reg. Sess. (Va. 2005); H.D. 2350, 2005 Gen. Assemb., Reg. Sess. (Va. 2005); H.D. 2352, 2005 Gen. Assemb., Reg. Sess. (Va. 2005); H.D. 2784, 2005 Gen. Assemb., Reg. Sess. (Va. 2005); S. 839, 2005 Gen. Assemb., Reg. Sess. (Va. 2005); H.D. 189, 2006 Gen. Assemb., Reg. Sess. (Va. 2006); H.D. 1378, 2006 Gen. Assemb., Reg. Sess. (Va. 2006); H.D. 2347, 2006 Gen. Assemb., Reg. Sess. (Va. 2006); S. 580, 2006 Gen. Assemb., Reg. Sess. (Va. 2006); H.D. 1883, 2007 Gen. Assemb., Reg. Sess. (Va. 2007); H.D. 670, 2008 Gen. Assemb., Reg. Sess. (Va. 2008); H.D. 894, 2008 Gen. Assemb., Reg. Sess. (Va. 2008); S. 437, 2008 Gen. Assemb., Reg. Sess. (Va. 2008); H.D. 393, 2010 Gen. Assemb., Reg. Sess. (Va. 2010).

23. *See, e.g.*, H.D. 116, 2004 Gen. Assemb., Reg. Sess. (Va. 2004) (failing to pass the Senate Committee on Education and Health); H.D. 189, 2006 Gen. Assemb., Reg. Sess. (Va. 2006) (same); H.D. 1883, 2007 Gen. Assemb., Reg. Sess. (Va. 2007) (same).

24. H.D. 1428, 2011 Gen. Assemb., Reg. Sess. (Va. 2011).

25. *Id.*

26. *See* H.D. 748, 2011 Gen. Assemb., Reg. Sess. (Va. 2011) (amending judicial procedure to bypass parental consent requirements for abortions performed on minors); H.D. 1428, 2011 Gen. Assemb., Reg. Sess. (Va. 2011) (requiring clinics performing twenty-five or more abortions annually to meet equipment requirements of ASCs); H.D. 1918, 2011 Gen. Assemb., Reg. Sess. (Va. 2011) (providing punishments for failing to meet building requirements for abortion clinics); H.D. 2147, 2011 Gen. Assemb., Reg. Sess. (Va. 2011)

TRAP legislation instead came in through the back door. Senate Bill 924 did not begin as a TRAP bill, but it clearly was positioned by antiabortion advocates as a vehicle to pass TRAP rules.[27] The bill began innocuously, dealing with infection prevention and disaster preparedness for hospitals, nursing homes, and certified nursing facilities in the Commonwealth.[28] But the House added an amendment that directed the Board of Health to promulgate regulations for women's health care centers in the state that provide abortion services.[29] As a House amendment, the new TRAP law went directly to the Senate floor, bypassing the Senate committee that, in the past, had kept TRAP laws from getting to the Senate floor.[30] The Senate accepted the amendment by vote of 20–20, the tie was broken by the Lieutenant Governor, and the TRAP law was passed and signed by the Governor.[31] The law directed the Board to craft temporary "emergency" regulations, although no public health emergency existed, and then final permanent rules.[32]

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(prohibiting insurance companies from selling over health care exchanges any policy that covers certain abortion procedures); H.D. 2192, 2011 Gen. Assemb., Reg. Sess. (Va. 2011) (excluding abortion from Medicaid benefits coverage); H.D. 2421, 2011 Gen. Assemb., Reg. Sess. (Va. 2011) (amending judicial procedure to bypass parental consent requirements for abortions performed on minors); S. 1202, 2011 Gen. Assemb., Reg. Sess. (Va. 2011) (prohibiting insurance companies from selling over health care exchanges any policy that covers certain abortion procedures); S. 1217, 2011 Gen. Assemb., Reg. Sess. (Va. 2011) (providing criminal punishments for forcing a woman to obtain an abortion); S. 1435, 2011 Gen. Assemb., Reg. Sess. (Va. 2011) (adding to informed consent requirements).

27. S. 924, 2011 Gen. Assemb., Reg. Sess. (Va. 2011), *available at* http://leg1.state.va.us/cgi-bin/legp504.exe?ses=111&typ=bil&val=sb924.

28. *Id.* (original version introduced on Jan. 1, 2011), *available at* http://leg1.state.va.us/cgi-bin/legp504.exe?ses=111&typ=bil&val=sb924.

29. *See* H.D. Amend., S. 924, 2011 Gen. Assemb., Reg. Sess. (Va. 2011) (classifying as a hospital any facility that performs five or more abortions per month and authorizing the Board of Health to promulgate rules regulating these facilities); VA. CODE ANN. § 32.1-127(B)(1) (West 2013) (codifying the above amendment).

30. *See* Va. B. Stat., 2011 S.B. 924 (2011) (tracking S.B. 924 through the Virginia General Assembly) (Westlaw).

31. *See id.* (tracking S.B. 924 through the Virginia General Assembly).

32. *See* § 32.1-127(A)(1) (West 2013) (authorizing the Board of Health to promulgate rules implementing Virginia's TRAP laws).

### *B. Administrative Process*

The regulatory process began when the Virginia Department of Health drafted temporary, "emergency" regulations for women's health care centers.[33] The Department of Health convened a medical committee, comprising OB/GYN department chairs from hospitals around the state, to work with the Department of Health to create the draft regulations.[34] After considering regulations implemented in other states and materials from the American Congress of Obstetricians and Gynecologists, Center for Disease Control, World Health Organization, and other public health organizations, the committee crafted draft regulations.[35] The committee's recommendations stipulated that stringent physical plant requirements would not apply to existing health centers.[36] Nonetheless, the Department of Health released, and the Board of Health approved, temporary regulations that imposed construction requirements meant for new hospitals on existing doctors' offices and clinics providing first-trimester abortions as part of women's health care services. [37]

With temporary regulations in effect starting January 1, 2012, the Board of Health considered permanent regulations worded exactly the same as the temporary ones, settling on regulations that became final on June 20, 2013.[38] At one point, the Board voted to amend a key provision of the permanent regulations; it approved an amendment to "grandfather in" existing women's health care centers rather than subject them to

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33. *See* Press Release, Va. Coal. to Protect Women's Health, Women's Health Providers and Advocates to Speak Out at Board of Health Hearing (Dec. 8, 2011), http://www.coalitionforwomenshealth.org/assets/bin/Va%20coalition%20-%20MA%20Press%20Conference%20-%2012-08-11.pdf [hereinafter Press Release] (discussing the drafting process for the temporary regulations).

34. *See id.* (discussing the drafting process for the temporary regulations).

35. *See id.* (discussing the drafting process for the temporary regulations).

36. *See id.* (noting that other Virginia regulations often "grandfather in" existing health care facilities).

37. *See* 28 Va. Reg. Regs. 925 (Jan. 16, 2012) (imposing construction requirements on first-trimester abortion clinics).

38. *See* Press Release, *supra* note 33 (describing the proposed permanent regulations as "medically irrelevant").

onerous and unnecessary physical plant standards.[39] However, as explained in more detail in Part III, the attorney general refused to certify the new regulations, saying that the law required the rules to be applied to existing facilities, and the Board adopted the new regulations without approving the "grandfather" provision.[40]

Most onerous among the regulations imposed on women's health care centers in Virginia are the architectural requirements.[41] In Virginia, TRAP goes further than similar laws in other states, requiring that women's health care centers meet hospital standards.[42] Virginia's TRAP rules require that within two years of the date of a clinic's initial licensure under the new rules, existing women's health centers must come into compliance with three chapters of the 2010 Guidelines for Design and Construction of Health Care Facilities of the Facilities Guidelines Institute.[43] The Guidelines are written, however, to apply exclusively to new hospital construction, and were never intended to apply to existing facilities.[44] There is no other instance in which Virginia has required existing healthcare facilities to

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39. *See id.* (noting that without this amendment, women's health care facilities would have to comply with certain architectural requirements under the temporary regulations and then with different architectural standards under the permanent regulations).

40. *See id.* (discussing the attorney general's involvement in promulgating the permanent regulations).

41. *See* 12 VA. ADMIN CODE § 5-412-370 (2011) (providing architectural requirements).

42. *See* Rachel Benson Gold & Elizabeth Nash, *TRAP Laws Gain Political Traction While Abortion Clinics—and the Women They Serve—Pay the Price*, 16 GUTTMACHER POL'Y REV. 7, 11 (2013), http://www.guttmacher.org/pubs/gpr/16/2/gpr160207.pdf (stating that these requirements are "unnecessary to protect patient safety").

43. 12 VA. ADMIN. CODE, § 5-412-370 (2011).

44. *See* FACILITY GUIDELINES INST., GUIDELINES FOR DESIGN AND CONSTR. OF HEALTH CARE FACILITIES ¶ 1.1-1.3.2, at 4 (2010) [hereinafter FGI GUIDELINES] (indicating that the guidelines are intended for the construction of new health care facilities). The Guidelines state that they are "intended as minimum standards for designing and constructing new health care facility projects." *Id.* at 4. Further, the Guidelines state that if existing facilities undertake significant renovations or additions, "only that portion of the total facility affected by the project shall be required to comply with the applicable section of these Guidelines." *Id.* at 6.

comply with regulations or guidelines designed for new construction.[45]

The new architectural standards applied through TRAP include separate rooms for telecommunications and computer equipment; drinking fountains in waiting rooms; six-inch handles on all sinks; larger procedure rooms; larger hallways; hospital-style heating, cooling, and ventilation systems; and covered entryways.[46] The Virginia Department of Health estimates that the total cost for women's health care centers across the state to make the required physical plant changes comes close to $15 million—an average cost of $700,000–$969,000 per site.[47]

Women's health care centers like Hillcrest that cannot afford these unnecessary costs will close. Others will stop providing abortion care or make abortion less accessible by raising the cost to pay for the required construction.[48] Any of these consequences directly curtail access to abortion care.[49]

## *III. Legal Flaws in the Adoption of TRAP*

The TRAP regulations result from a deeply flawed administrative process. Procedurally, disregard for Virginia's Administrative Process Act and interference by the attorney general call into question the legitimacy of the adoption process.[50]

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45. *Compare* 12 VA. ADMIN. CODE 12, § 5-412-370 (abortion facilities), *with id.* § 5-410-650 (hospitals), *id.* 12, § 5-410-1350 (outpatient surgical centers), *id.* § 5-371-410 (nursing homes), *and* tit. *id.* § 5-391-440 (hospices).

46. *See* Katherine Greenier, *Virginia Still Has Time to Spring TRAP Law*, WENEWS (Feb. 21, 2012), http://womensenews.org/story/abortion/120220/virginia-still-has-time-spring-trap-law?page=0,0#.Ur3-e_bsq7l (last visited Jan. 22, 2014) ("Such burdensome architectural changes are unrelated to patient safety and could cost providers a minimum of tens of thousands of dollars.") (on file with the Washington and Lee Law Review).

47. VA. REGULATORY TOWN HALL, PROPOSED REGULATION AGENCY BACKGROUND DOCUMENT 10 (2013), http://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\58\3563\6315\AgencyStatement_VDH_6315_v2.pdf [hereinafter AGENCY BACKGROUND DOC.].

48. *See* Jeter, *supra* note 3 (noting that the Hillcrest Clinic closed its doors rather than comply with the costly regulations).

49. *See* Adelman, *supra* note 3 (arguing that TRAP laws are designed intentionally to limit access to abortion care).

50. *See* Press Release, *supra* note 33 (discussing the attorney general's involvement promulgating the TRAP regulations).

Substantively, the resulting regulations are inconsistent with the authorizing statute, the comprehensive regulatory scheme, and the advice of the panel of medical experts convened by the Board itself.[51]

### *A. Statutory and Regulatory Background*

Prior to 2011, Virginia law required the Board to adopt regulations governing the construction and maintenance of "hospitals, nursing homes and certified nursing facilities."[52] Such regulations were to "include minimum standards for the design and construction of hospitals . . . consistent with the current edition of the Guidelines for Design and Construction of Hospital and Healthcare Facilities issued by the American Institute of Architects Academy of Architecture for Health."[53]

The Guidelines cited in the statute are expressly "intended as minimum standards for designing and constructing new healthcare facility projects."[54] The Guidelines further provide that when substantial renovations are made to a facility, "only that portion of the total facility affected by the project shall be required to comply with the applicable section of these guidelines."[55] Accordingly, Board regulations adopted pursuant to that statute pertaining to hospitals and nursing homes only required new facilities and substantial renovations of old facilities to comply with the FGI Guidelines.[56]

In 2011, the General Assembly added the following language to Section 32.1-127: "For purposes of this paragraph, facilities in

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51. *See id.* (discussing the regulations recommended by medical experts). Many of the procedural irregularities and substantive flaws described here are the subject of an ongoing lawsuit challenging the TRAP regulations. Falls Church Med. Ctr. v. Va. Bd. of Health, No. CL 13001362-00 (Va. Cir. Ct. June 10, 2013).

52. VA. CODE ANN. § 32.1-127(B)(1) (West 2004 & Supp. 2008).

53. *Id.* § 32.1-127.001. These guidelines are now known as the Facility Guidelines Institute Guidelines for Design and Construction of Healthcare Facilities. FGI GUIDELINES, *supra* note 44.

54. FGI GUIDELINES, *supra* note 44, ¶ 1.1-1.3.2, at 4.

55. *Id.* ¶ 1.1-3.2, at 6.

56. *See* 12 VA. ADMIN. CODE § 5-371-410 (2013) (applying local ordinances and FGI guidelines to the construction of new nursing facilities); *Id.* § 5-410-650 (applying the same requirements to new hospitals).

which five or more first trimester abortions per month are performed shall be classified as a category of 'hospital.'"[57] The new language requires the Board to adopt architectural regulations for women's health clinics that are consistent with the FGI Guidelines.[58]

To be consistent with the statutory language, the FGI Guidelines, and the Board's existing regulation of hospitals and nursing homes, the regulations should have included a "grandfather clause" exempting existing facilities.[59] Instead, deviations from the statutory procedure and ideologically-driven legal advice from the attorney general resulted in regulations that require all abortion facilities to comply with the FGI Guidelines.[60]

### *B. Virginia's Administrative Process Act*

The Virginia Administrative Process Act (APA)[61] governs the rulemaking procedure for the Board and other agencies. The process begins with the agency's issuance of a Notice of Intended Regulatory Action (NOIRA), which is published in the Virginia Register and subjected to a thirty-day public comment period.[62] The agency drafts a proposed rule, which is submitted to the Department of Planning and Budget (DPB) for an economic impact analysis.[63] The proposed rule is then published in the Virginia Register, and a sixty-day public comment period follows.[64] The attorney general and Governor review the rules, and the Governor transmits his comments, including any

57. VA. CODE ANN. § 32.1-127(B)(1) (West 2013).

58. *Id.* § 32.1-127.001.

59. *See* Press Release, *supra* note 33 (noting that medical experts recommended a grandfather clause to the Board of Health).

60. *See id.* (noting the attorney general's involvement in the promulgation of the TRAP regulations).

61. VA. CODE ANN. § 2.2-4000 to -4031.

62. *Id.* § 2.2-4007.01(A)(i)–(ii).

63. *Id.* § 2.2-4007.04(A).

64. *See id.* § 2.2-4007.05 (requiring publication of the proposed rule in the Virginia Register); *id.* § 2.2-4007 (allowing for public comment on proposed rules published in the Virginia Register).

recommended amendments or modifications, to the agency.[65] The agency passes the regulation in final form, with or without any modifications recommended by the Governor, and submits it for publication in the Virginia Register.[66] Unless further regulatory, legislative, or executive action is taken, the regulation takes effect thirty days after publication.[67]

As explained below, however, a gubernatorial executive order allowed executive branch officials to interfere with the regulatory process to a degree not contemplated by the APA.[68] As a result, the final regulations reflected the political and ideological priorities of the attorney general rather than women's health concerns as articulated by the medical experts who advised the Board of Health in the regulatory process.[69]

### *C. Adoption of the TRAP Regulations*

The Board adopted a proposed regulation on June 15, 2012, that required abortion facilities to comply with the FGI Guidelines.[70] However, consistent with regulations the Board had previously promulgated for nursing homes and hospitals, the proposed regulation would have "grandfathered" existing facilities, applying the FGI Guidelines only to new construction and renovations.[71]

Under the APA, the proposed regulation should have been submitted to the DPB for an economic impact analysis and then undergone a public comment period.[72] Instead, an executive order[73] issued by Governor Bob McDonnell interposed an

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65. *Id.* § 2.2-4013(A).

66. *Id.* §§ 2.2-4012(E), -4013(A).

67. *Id.* §§ 2.2-4012 to -4015.

68. *Infra* Part III.C.

69. *See* Press Release, *supra* note 33 (discussing the attorney general's involvement in the promulgation of the TRAP rules).

70. *See id.* (discussing the Board's proposed rules).

71. *See id.* (discussing the Board's proposed rules); 12 VA. ADMIN. CODE, § 5-410-650 (2014) (grandfathering in hospitals); tit. 12, § 5-371-410 (grandfathering in nursing homes).

72. *See* VA. CODE ANN. § 2.2-4007(A) (2013) (requiring an economic impact analysis for all proposed rules).

73. Exec. Order No. 14 (2010), http://www.governor.virginia.gov/

additional step in the process. Without statutory authorization, the executive order required each proposed regulation to receive a certification from the attorney general that the agency has legal authority to promulgate it before the agency may submit it to DPB for an economic impact analysis.[74] Thus, by refusing to certify a proposed regulation, the attorney general could prevent the submission of a regulation to DPB, the sixty-day public comment period, and all subsequent steps in the regulatory process.[75] The attorney general certification requirement was contrary to the letter and the spirit of the APA, which contemplates review and advice by the attorney general and Governor but grants ultimate authority to the regulatory agency to accept or ignore that advice.[76]

In a memorandum to the director of the Department of Health, the attorney general refused to certify the regulations as long as the grandfather clause was in place.[77] A later memorandum to the Board elaborated the attorney general's position.[78] The memorandum stated that, although the Board is not required to follow the advice of the attorney general, the attorney general could choose not to represent Board members who failed to follow his advice in subsequent litigation.[79] (The memorandum did not explain how such litigation would arise, given that a grandfather clause would not cause any party an

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policyoffice/executiveorders/viewEO.cfm?eo=14&pdf=yes [hereinafter Executive Order] (imposing Executive review of new and revised regulations).

74. *Id.*

75. *See* VA. CODE ANN. § 2.2-4007.04(A) (requiring an economic impact analysis from the DPB before initiating the public comment period).

76. *Id.* §§ 2.2-4012(E), 4013(A).

77. *See* Memorandum from Allyson K. Tysinger, Senior Assistant Attorney Gen., to Dr. Karen Remley, Comm'r, Va. Dep't of Health (July 16, 2012) ("Because 12 VAC 5-412-370 conflicts with Virginia Code § 32.1-127.001, the Board has exceeded its authority. Thus, this Office cannot certify these Regulations.") (on file with the Washington and Lee Law Review).

78. *See* Memorandum from Allyson K. Tysinger, Senior Assistant Attorney Gen., to Members of the Va. Bd. (Sept. 12, 2012) (expounding upon the attorney general's position and responding to questions submitted by the Board) (on file with the Washington and Lee Law Review).

79. *Id.* at 2 ("Board members may refuse to follow the advice of the Attorney General. Should a Board member choose to disregard the Attorney General's advice . . . , the Attorney General is not obligated to provide representation . . . .").

"injury in fact" that could give rise to standing to sue.) Moreover, while disclaiming any authority to "veto" policy decisions by the Board, the memo asserted that "[w]ithout certification from the Attorney General, a regulation cannot move forward in the regulatory process."[80] Finally, the memorandum contended that the proposed regulation's grandfather provision violated the statute requiring "hospitals," now defined to include abortion facilities, to conform to the FGI Guidelines.[81]

The attorney general's advice ignored the fact that the FGI Guidelines themselves state that they are limited to new construction and renovation rather than existing facilities.[82] Thus, application of the Guidelines to existing facilities is not "consistent" with the Guidelines.[83] The attorney general also ignored the fact that regulations governing hospitals and nursing homes, adopted under the same statutory requirements, also exempted existing facilities.[84]

After receiving the attorney general's memorandum on September 15, 2012, the Board revised the proposed regulations to eliminate the grandfather clause and require existing facilities to comply with the FGI Guidelines.[85] Following public comment, the Board finalized the regulations without the grandfather clause.[86]

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80. *Id.* (citing Executive Order, *supra* note 73).

81. *Id.* at 3–4.

82. *See* FGI GUIDELINES, *supra* note 44, ¶ 1.1-1.3.2, at 4 (noting that the guidelines are intended for the construction of new health care facilities).

83. *See id.* (noting that the guidelines are intended for the construction of new health care facilities).

84. *See* tit. 12, § 5-410-650 (grandfathering in hospitals); tit 12, § 5-371-410 (grandfathering in nursing homes).

85. *See* 29 Va. Reg. Regs. 1526 (Jan. 28, 2013) (noting that the "primary disadvantage to the public associated with the proposed action is some abortion facilities may need to renovate or relocate their facility in order to comply with the regulations").

86. *See* 29 Va. Reg. Regs. 2341 (May 20, 2013) (forcing all abortion clinics to comply with state and local building codes as well as the FGI guidelines).

### *D. Additional Legal Defects*

As explained above, the attorney general's interference in the regulatory process violated the APA and resulted in a regulation that violated the statutory requirement that the architectural requirements for abortion facilities be consistent with the FGI Guidelines.[87] The elimination of the grandfather clause also conflicted with two additional legal requirements.

First, the authorizing statute requires regulation of abortion facilities to be "in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety."[88] Early in the regulatory process, the Board convened a panel of public health experts, who advised the Board that the application of the FGI Guidelines to existing facilities was unduly onerous and medically unnecessary.[89] The Board's initial proposed regulation, which exempted existing facilities, reflected the expert's advice, but the attorney general's refusal to certify the regulation led the Board to remove the exemption.[90] The Board's final regulation conflicts with the authorizing statute.[91]

Second, the APA requires agencies to "prepare regulatory flexibility analysis in which the agency shall consider utilizing alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small businesses."[92] The Board determined that the cost to

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87. *See* Press Release, *supra* note 33 (noting the attorney general's involvement in the promulgation of the TRAP rules).

88. VA. CODE ANN. § 32.7-127(A) (West 2013).

89. *See* Andrew M. Klein et al., *Regulation for Licensure of Abortion Facilities*, VA. REG. TOWN HALL (Mar. 26, 2013, 3:16 PM), http://townhall.virginia.gov/L/viewcomments.cfm?commentid=27082 (last visited Mar. 1, 2014) (summarizing the expert recommendations) (on file with the Washington and Lee Law Review); Press Release, *supra* note 33 (discussing the expert recommendations).

90. *See* Press Release, *supra* note 33 (discussing the attorney general's involvement in the promulgation of the TRAP rules).

91. *See* 12 VA. ADMIN. CODE § 5-412-370 (2011) (applying the TRAP regulations to new and existing abortion clinics).

92. VA. CODE ANN. § 2.2-4007.1.

abortion facilities of compliance with the regulations could range from $75,000 to $6 million.[93] Nonetheless, the agency's "regulatory flexibility analysis" concluded that due to the attorney general's advice, no exemptions from the regulations could be made to ease the burden on small businesses.[94] This result is inconsistent with the APA's flexibility analysis requirement.[95]

### *IV. TRAP Undermines the Constitutional Right to Abortion*

States have the power to regulate abortion for the purposes of public health.[96] Just after the Supreme Court's decision in *Roe v. Wade*, several states attempted to enact regulations on abortion clinics that went beyond measures necessary to ensure the public's health and safety.[97] Lower federal courts intervened to strike down many of those attempts.[98] As a result, in the early 1980s, states tried other tactics to curtail abortion access.[99] In the 1990s, TRAP laws became a key tactic in this effort to undermine abortion by other means—essentially by regulating abortions out of

93. 29 Va. Reg. Regs. 1527 (Jan. 28, 2013).

94. *See* AGENCY BACKGROUND DOC., *supra* note 47, at 11 (noting under the regulatory flexibility analysis that these regulations are consistent with practices in other states). Additionally, Executive Order 14 requires agencies to "identify and assess the least costly means including reasonably available alternatives in lieu of regulation for achieving the goals of a regulation," but no such assessment was included in the agency's regulatory flexibility analysis. Executive Order, *supra* note 73.

95. *See* VA. CODE ANN. § 2.2-4007.1 (West 2013) (requiring a regulatory flexibility analysis for all proposed rules).

96. *See* Roe v. Wade, 410 U.S. 113, 149 (1973) (noting that the state has an important interest in maintaining health and medical standards); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 846 (1992) (reaffirming the holding in *Roe* that states may regulate abortion to protect public health).

97. *See* Gold & Nash, *supra* note 42, at 8 (noting that lower courts invalidated most of these burdensome regulations).

98. *See id.* (noting that in light of the failure to regulate patients themselves, anti-choice advocates began to regulate abortion providers instead).

99. *See id.* (noting that these tactics included denying public funding for abortions and passing informed consent laws).

existence.[100] TRAP laws have become even more popular in the past few years.[101]

Among the attempted restrictions on abortion following *Roe*, the Supreme Court struck down a requirement that any abortion after the first trimester of pregnancy be performed in a hospital (because abortions can be safely provided in other clinical settings).[102] In that case, the Supreme Court also made clear that such regulation is allowed only if justified by medical evidence.[103] Later, in *Planned Parenthood v. Casey*,[104] the Court stated that "as with any medical procedure," states may not place "unnecessary health regulations that present a substantial obstacle to a woman seeking an abortion."[105] The importance of medical evidence to justify regulation of abortion goes back to *Roe* and its companion case, *Doe v. Bolton*;[106] *Roe* relies on medical evidence to decide the parameters of allowable state regulation of abortion, and *Doe* held unconstitutional a requirement that all abortions be performed in a licensed, accredited general hospital.[107] As the Center for Reproductive Rights explained in a letter to the Virginia State Health Commissioner during the TRAP regulatory process, "medical justification is the touchstone for permissible state regulation of abortion."[108]

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100. *See id.* at 7 (arguing that TRAP laws "have nothing to do with protecting women and everything to do with shutting down clinics").

101. *See id.* at 8 (noting that twenty-seven states have implemented some form of TRAP laws).

102. *See* City of Akron v. Akron Ctr. for Reprod. Health, 462 U.S. 416, 431–33 (1983) (holding that hospitalization requirements for second- and third-trimester abortions are invalid under *Roe v. Wade*), *overruled by* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992).

103. *See id.* at 428–30, 475 nn.11–12 (noting that states can only regulate abortions prior to the third trimester to serve the public health).

104. 505 U.S. 833 (1992).

105. *Id.* at 878.

106. 410 U.S. 179 (1973).

107. *See* Roe v. Wade, 410 U.S. 113, 163 (1973) (developing a trimester framework based on "present medical knowledge"); *Doe*, 410 U.S. at 195 (noting that the state failed to present any data showing that accredited hospitals increase the safety of the abortion procedure).

108. Letter from Michelle Movahed, Staff Attorney, Ctr. for Reprod. Health, to Karen Remley, Comm'r, Va. Dep't of Health (Sept. 5, 2012), http://www.coalitionforwomenshealth.org/assets/bin/CRR%20written%20testimony.pdf.

While medical professionals indicate that first-trimester abortions are performed safely in a doctor's office or clinical setting, according to the Guttmacher Institute, "[n]early all TRAP laws dictate that abortions need to be performed at sites that are the functional equivalent of ambulatory surgical centers, or even, in a few cases, hospitals."[109] Virginia's regulations are among the few that require women's health care centers to meet standards set for hospitals,[110] even though the Supreme Court has held unconstitutional a requirement that any abortion after the first trimester of pregnancy be performed in a hospital.[111] (Indeed, first-trimester abortion is even safer and less complicated than second-trimester abortion,[112] making Virginia's hospital standards for first-trimester abortion providers even less justifiable.) Virginia's TRAP laws thus make plain that the aim is not to protect women's health but actually to undermine women's access to reproductive health care.[113]

When medical professionals from across the state, and across the country, maintain that TRAP is unrelated to patient health and safety and acts as an unnecessary burden on women's health care centers, the true nature of these regulations becomes clear: To target abortion and restrict access to the procedure.[114]

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109. Gold & Nash, *supra* note 42, at 9.

110. *See id.* at 11 (describing Virginia's TRAP laws as "unnecessary to protect patient safety").

111. *See* City of Akron v. Akron Ctr. for Reprod. Health, 462 U.S. 416, 431–33 (1983) (holding that hospitalization requirements for second and third trimester abortions are invalid under *Roe v. Wade*).

112. *See* GUTTMACHER INST., FACTS ON INDUCED ABORTION IN THE UNITED STATES 2 (2013), http://www.guttmacher.org/pubs/fb_induced_abortion.pdf [hereinafter FACTS ON ABORTION] (noting that first-trimester abortions pose virtually no long-term risk to the woman's health).

113. *See* Gold & Nash, *supra* note 42, at 7 (arguing that TRAP laws and regulations "have nothing to do with protecting women and everything to do with shutting down clinics").

114. *See* Andrea Rowan, *Physicians' Groups Respond to TRAP Laws Passed During 2013 Legislative Session*, 16 GUTTMACHER POL'Y REV. 20, 20 (2013), http://www.guttmacher.org/pubs/gpr/16/3/gpr160320.pdf (arguing that TRAP laws have a "chilling" effect on the availability of safe and legal abortions).

### *V. The New Regulations for Women's Health Care Centers in Virginia Are Unnecessary and Unrelated to Health and Safety*

It is important to recognize that the rules we are talking about apply only to doctors' offices and clinics performing first-trimester abortions.[115] Virginia law already requires second- and third-trimester abortions to be performed in licensed hospitals.[116] There are two common types of first-trimester abortion procedures: medication abortion and surgical abortion.

Taking medications that will end a pregnancy is called a medication abortion.[117] Mifepristone or methotrexate can be used for medication abortion, and either medication is taken together with misoprostol to induce an abortion.[118] Medication abortion is effective generally up to nine weeks gestation and allows a woman to have a safe, effective abortion without a surgical procedure.[119]

Surgical abortion ends a pregnancy by emptying the uterus with special instruments.[120] Virtually all first-trimester surgical abortions are accomplished by vacuum aspiration, which involves very light suction applied to the contents of the uterus.[121] A

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115. *See* 12 VA. ADMIN. CODE § 5-412-10 to -370 (2013) (providing comprehensive regulation of first-trimester abortion facilities).

116. VA. CODE ANN. §§ 18.2-73, 74 (West 2013). While the Supreme Court in *Simopoulos v. Virginia*, 462 U.S. 506 (1983), allowed Virginia to regulate second-trimester abortion providers based on standards for outpatient surgical hospitals, standards for outpatient surgical hospitals are not as strict as the standards for general hospitals, and the medical evidence showed that the law was consistent with medical standards. *Id.* at 517. Plus, the regulations at issue in *Simopoulos* provided waivers of construction standards, and the regulations of first-trimester abortion providers in Virginia only allow temporary waivers. *Id.* at 517.

117. *See* NAT'L ABORTION FED'N, WHAT IS MEDICAL ABORTION 1 (2008), http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/medical_abortion.pdf (defining medical abortion).

118. *See id.* at 1 (discussing the different medications used in medical abortions).

119. *See id.* at 1–2 (discussing possible complications arising from a medical abortion).

120. *See* Comment from Va. Coal. to Prot. Women's Health to Va. Bd. of Health 12 (Feb. 15, 2001), http://www.coalitionforwomenshealth.org/assets/bin/Coalition%20Comments%20for%20the%20BoH%202%2015%2012.pdf (commenting on the TRAP regulations).

121. *Id.* at 12.

routine first-trimester surgical abortion takes approximately five to fifteen minutes to complete and is one of the safest types of medical procedures.[122]

By treating abortion, specifically first-trimester abortion, differently from all other comparable medical procedures routinely performed in doctors' offices and clinics, TRAP laws segregate first-trimester abortion providers and patients from the rest of medical practice without any medical reason.[123] Complications occur in less than one-half of one percent of all procedures.[124] Abortion care entails one-thousandth the risk of death involved in an appendectomy, a common, in-office surgical procedure.[125] The complication rate from abortion is vastly lower than that of breast augmentation, another procedure commonly performed in physicians' offices.[126]

Serious complications arising from surgical abortions provided before thirteen weeks are quite unusual.[127] About 88% of the women who obtain abortion care are less than thirteen weeks pregnant.[128] Of these women, 97% report no complications; 2.5%

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122. *Id.*

123. *See* Gold & Nash, *supra* note 42, at 11 (stating that TRAP laws are "unnecessary to protect patient safety").

124. *See* FACTS ON ABORTION, *supra* note 112 ("Abortion is one of the safest medical procedures, with minimal—less than 0.5%—risk of major complications that might need hospital care.").

125. *Compare* Caprice C. Greenberg, *"Recurrent" Appendicitis*, AGENCY FOR HEALTHCARE RES. & QUALITY, www.webmm.ahrq.gov/case.aspx?caseID=225#ref2back (last visited Jan. 22, 2014) (noting that the mortality rate for appendectomy for the general population is less than 1%) (on file with the Washington and Lee Law Review), *with* L.A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 OBSTETRICS & GYNECOLOGY 729, 732 (2004) (noting that the overall death rate during 1988–1997 for women obtaining legally induced abortions was 0.7 per 100,000 abortions, or .0007%).

126. *See Risks of Breast Implants*, U.S. FOOD & DRUG ADMIN., http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/ImplantsandProsthetics/Breastimplants/ucm064106.htm (last updated Sept. 25, 2013) (last visited Jan. 22, 2014) (discussing the risks associated with breast augmentation surgery) (on file with the Washington and Lee Law Review).

127. *See* NAT'L ABORTION FED'N, SAFETY OF ABORTION 1 (2010), http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/safety_of_abortion.pdf [hereinafter SAFETY OF ABORTION] (comparing the dangers of illegal abortion to the safety of legal abortion).

128. *Id.* at 1.

have minor complications that can be handled at the medical office or abortion facility; and less than 0.5% have more serious complications that require some additional surgical procedure and/or hospitalization.[129] The mortality rate for legal surgical abortions in the first nine weeks of pregnancy is one in one million and for the first trimester of pregnancy is only four in one million.[130]

In addition, first-trimester abortions pose virtually no long-term risk of such problems as infertility, ectopic pregnancy, spontaneous abortion (miscarriage), or birth defect, and little or no risk of preterm or low-birth-weight deliveries.[131]

The Guttmacher Institute summarizes the statistics on the provision of abortion care safely in clinics and doctor's offices:

> Research from the Centers for Disease Control and Prevention on abortions performed between 1974 and 1977 found no difference in the risk of death between procedures performed in a hospital and those performed in a clinic or a physician's office. More recent studies have also found low complication rates for abortions performed in outpatient settings. According to the American College of Obstetricians and Gynecologists (ACOG), providing abortions in the context of private practice is entirely appropriate, as long as physicians who do so in their offices are equipped to handle any emergencies that arise.[132]

Over the course of the rulemaking process, Virginia's medical community actively opposed these new rules as unduly onerous and medically unnecessary.[133] For example, in June 2012, Dr. James "Jef" Ferguson of the University of Virginia School of Medicine, one of six top medical experts from across Virginia asked to advise the state on drafting the regulations,[134] publicly

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129. *Id.* at 1.

130. *See* Bartlett et al., *supra* note 125, at 733 (comparing mortality rate for abortion procedures across gestational age of the fetus).

131. *See* FACTS ON ABORTION, *supra* note 112 (discussing the long-term risks associated with abortion).

132. Gold & Nash, *supra* note 42, at 7.

133. *See Medical Experts: Virginia Abortion Regulations Based on Politics, Not Safety*, ABC NEWS (Dec. 3, 2011, 5:53 PM), http://www.wjla.com/articles/2011/12/medical-experts-virginia-abortion-regulations-based-on-politics-not-safety-69 899.html (last visited Jan. 22, 2014) (discussing criticism of the TRAP laws by medical experts in the state) (on file with the Washington and Lee Law Review).

134. *See id.* (discussing Dr. Ferguson's criticism of the TRAP laws).

denounced the final regulations. Dr. Ferguson called the regulations politically motivated, saying that "arbitrary and capricious decisions like this—in my opinion—have no place in the practice of medical care and disruption that's occurring . . . women's health care should not be politically motivated."[135] He stated that he "couldn't support the unnecessary regulations related to building codes and the like, as they didn't have anything to do with improving patient care and safety," and along with several of the medical experts on the committee asked for his name to be removed from the final regulations.[136]

In September 2012, a diverse group of doctors from across the state, including the Virginia section of the American College of Obstetrics and Gynecology (ACOG), organized and independently funded a public letter and *Richmond Times-Dispatch* advertisement,[137] which they also posted as a public comment on the Virginia Townhall website, an online resource provided by the state for information about proposed changes to Virginia's regulations and for public participation through online comment forums.[138] Additionally, the Virginia section of ACOG submitted public comment to the Board of Health separately, stating that "[w]omen's health care in Virginia is threatened by the new regulations including unnecesary [sic] architectural restrictions that do nothing to enhance patient safety."[139] In

135. Prue Salasky, *Board of Health to Vote on Permanent Regulations for Va. Abortion Facilities Friday*, DAILY PRESS (June 15, 2012, 7:31 AM), http://www.dailypress.com/health/health-notes-blog/dp-health-notes-permanent-regulations-for-va-abortion-facilities-friday-20120615,0,283776.story (last visited Jan. 22, 2014) (quoting Dr. Ferguson) (on file with the Washington and Lee Law Review).

136. Dietrich, *supra* note 20.

137. *See* Memorandum from Healthcare Providers in Va. to the Va. Bd. of Health, https://acluva.org/wp-content/uploads/2013/10/FInal-Med-Prof-Letter-BOH-RTD.pdf (showing criticism of the TRAP regulations from 177 Virginia physicians).

138. *See* Andrew M. Klein et al., *Regulation for Licensure of Abortion Facilities*, VA. REG. TOWN HALL (Mar. 26, 2013, 3:16 PM), http://townhall.virginia.gov/L/viewcomments.cfm?commentid=27082 (last visited Jan. 22, 2014) (showing criticism of the TRAP regulations from 177 Virginia physicians) (on file with the Washington and Lee Law Review).

139. Christian Chisholm, *Regulation for Licensure of Abortion Facilities*, VA. REG. TOWN HALL (Mar. 5, 2013, 11:28 PM), http://townhall.virginia.gov/L/viewcomments.cfm?commentid=26389 (last visited Jan. 22, 2014) (on file with the Washington and Lee Law Review).

October 2012, Dr. Karen Remley, the Virginia Health Commissioner, resigned her position because of what she characterized as the intrusion of politics into women's health care.[140]

The bottom line is that first-trimester abortions are routinely and safely provided as an outpatient procedure in doctor's offices; in fact, the Guttmacher Institute reports that nearly all U.S. abortions take place in nonhospital settings.[141] Thus, imposing hospital standards on women's health care centers providing abortion care is discriminatory, unnecessary, and unreasonably and unduly burdens a woman's ability to exercise her right to abortion.[142]

### *VI. The Effect of TRAP in Virginia, Including TRAP's Impact on Access to Abortion for Low-Income Women*

Although they are not identical to Virginia's regulations, TRAP laws in Alabama and Texas illustrate the negative effect of TRAP on women's access to abortion.[143] In those states, TRAP laws require abortion providers to receive admitting privileges from area hospitals.[144] Like Virginia's TRAP, those laws impose significant extra costs on abortion providers with the closure of some clinics an inevitable result.[145] Expert reports submitted in litigation against the Alabama and Texas TRAP laws

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140. *See Va. Health Chief Resigns over New Abortion Clinic Rules*, USA TODAY (Oct. 18, 2012, 6:56 PM), http://www.usatoday.com/story/news/ondeadline/2012/10/18/virginia-health-commissioner-resigns/1642197/ (last visited Jan. 22, 2014) (noting that Dr. Remley resigned because the TRAP regulations were applied to existing abortion clinics) (on file with the Washington and Lee Law Review).

141. *See* FACTS ON ABORTION, *supra* note 112 (presenting statistics on nonhospital abortion procedures).

142. *See* Gold & Nash, *supra* note 42, at 11 (stating that TRAP laws are "unnecessary to protect patient safety").

143. *See* H.R. 57, 2013 Leg. Reg. Sess. (Ala. 2013) (requiring hospitals to provide nearby abortion physicians with staff privileges at the hospital); S. 1198, 2013 Leg., 83d Sess. (Tex. 2013) (same).

144. H.R. 57, 2013 Leg., Reg. Sess. (Ala. 2013); S. 1198, 2013 Leg., 83d Sess. (Tex. 2013).

145. *See* Gold & Nash, *supra* note 42, at 8 (arguing that Virginia's TRAP laws are designed to close abortion clinics).

demonstrate that such closures have a severe impact on the reproductive choices on low-income women.[146] Expert reports from both the Alabama and Texas litigation cited the barriers to travelling long distances faced by low-income women, which include transportation, time away from work, and time away from home (necessitating child care).[147] The closure of clinics resulting from TRAP would increase the distances low-income women would be required to travel to receive abortion services, ultimately preventing some women from obtaining abortions they would have otherwise obtained.[148]

Experts in Alabama noted that "research shows that increasing the distance women must travel to obtain an abortion decreases the abortion rate," particularly affecting low-income women because "increasing the travel distance increases the

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146. *See, e.g.*, Expert Report of Shelia M. Katz at 13, Planned Parenthood Se. v. Bentley, No. 2:13CV405–MHT, 2013 WL 3287109 (M.D. Ala. June 28, 2013) (2:13-cv-405-MHT) ("In order for a low-income or near low-income woman to afford the additional cost associated with the new law, she would have to make severe financial sacrifices and hard decisions."); Expert Report of Stanley K. Henshaw at 12, Planned Parenthood Se. v. Bentley, No. 2:13CV405–MHT, 2013 WL 3287109 (M.D. Ala. June 28, 2013) (2:13-cv-405-MHT) ("In summary, it is my opinion that the Act will pose serious burdens for many women seeking abortions in Alabama."); Expert Report of Joseph E. Potter at 9–10, Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott, 734 F.3d 406 (5th Cir. 2013) (No. 13–51008) ("Furthermore, the burden of travel is higher for younger women, women of color, and low-income women, who have fewer resources to overcome the increased cost of further travel.").

147. Expert Report of Shelia M. Katz, *supra* note 146, at 6–14 (describing various costs and burdens of extensive travel for abortions); Expert Report of Stanley K. Henshaw, *supra* note 146, at 12 (same); Expert Report of Joseph E. Potter, *supra* note 146, at 9–10 ("Furthermore, the burden of travel is higher for younger women, women of color, and low-income women, who have fewer resources to overcome the increased cost of further travel.").

148. Expert Report of Shelia M. Katz, *supra* note 146, at 14 ("I believe significant numbers of low-income women in those cities, and indeed in the surrounding areas that those cities serve, will not be able to obtain abortions they would seek as a result of the closure of the clinics in those cities."); Expert Report of Stanley K. Henshaw, *supra* note 146, at 12 ("In summary, it is my opinion that the Act will pose serious burdens for many women seeking abortions in Alabama, and that for a substantial number of women, these burdens will prevent them from obtaining abortions."); Expert Report of Joseph E. Potter, *supra* note 146, at 9–10 ("Furthermore, the burden of travel is higher for younger women, women of color, and low-income women, who have fewer resources to overcome the increased cost of further travel.").

financial cost and logistical hurdles of obtaining an abortion."[149] An expert in Texas stated, "[l]imited access to abortion providers, and abortions provider closings in particular, are associated with reduced abortion service provision and lower abortion rates . . . ."[150]

As in Alabama and Texas, the closure of clinics as a result of TRAP is likely to have the greatest impact on low-income women.[151] Approximately 213,696 women between the ages of eighteen and forty-four live below the federal poverty line in Virginia.[152]

Guttmacher reports that in 2008, 28,520 women obtained abortions in Virginia.[153] In the United States as a whole, 42% of women having abortions had incomes below the federal poverty level and another 27% had incomes below 200% of the federal

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149. Expert Report of Stanley K. Henshaw, *supra* note 146, at 2.

150. Expert Report of Joseph E. Potter, *supra* note 146, at 9.

151. Expert Report of Stanley K. Henshaw, *supra* note 146, at 14 ("Increases in the cost associated with obtaining an abortion have a major impact on the ability of low-income women to access abortion services."); Expert Report of Shelia M. Katz, *supra* note 146, at 14 ("It is my opinion that this increased cost in money, increased time required, logistical challenges, and psychological hurdles for low-income women in Mobile, Montgomery, and Birmingham.").

152. *Easy Stats*, U.S. CENSUS BUREAU, http://www.census.gov/easystats/ (last visited Jan. 22, 2014) (accessed by selecting "Virginia," "Financial," and "Poverty Status in the Past 12 months by Sex and Age") (on file with the Washington and Lee Law Review). The United States Department of Health and Human Services defines the federal poverty line as a single person who makes less than $11,490 per year, with an additional $4,020 per year for each additional member of the household. Annual Update of the HHS Poverty Guidelines, 78 Fed. Reg. 5182, 5183 (Jan. 24. 2013). However, an expert in the litigation noted above explained:

> The federal poverty line, although used in many statistics, is generally considered an inadequate measure of poverty in the United States. The guideline is based on a formula from the 1960s assuming families spend approximately one-third of their budget on food, which is no longer the case amid rising costs for housing and transportation. The guideline also does not take into account other costs most families pay, such as for child care, medical expenses, utilities, and taxes.

Expert Report of Shelia M. Katz, *supra* note 146, at 4.

153. GUTTMACHER INST., STATE FACTS ABOUT ABORTION: VIRGINIA 1 (2014), http://www.guttmacher.org/pubs/sfaa/pdf/virginia.pdf [hereinafter VA. ABORTION FACTS]. The Guttmacher Institute notes: "Some of these women were from other states, and some Virginia residents had abortions in other states, so this rate may not reflect the abortion rate of state residents." *Id.* at 1.

poverty level.[154] So, 69% of women seeking abortions nationally are economically disadvantaged.[155] Given these numbers and Virginia's rate of poverty, it is clear that a majority of women who are seeking abortions in Virginia are below, at, or near the poverty line.[156]

In 2008, 85% of Virginia counties had no abortion provider.[157] 54% of Virginia women lived in these counties.[158] If more clinics close, all residents of Virginia will suffer an increased lack of access to abortion care and the comprehensive reproductive health care services provided by women's health care centers.[159] As noted above, however, the burdens of travel will affect low-income women the most.[160] These burdens are exacerbated by Virginia's ultrasound and twenty-four-hour waiting period requirements, which increase the travel involved as well as costs associated with missed work or child care.[161] For women already struggling to pay for the cost of the procedure itself, these additional obstacles will undoubtedly prevent some low-income women from obtaining abortions.[162]

## *VII. Where Do We Go from Here?*

As we have explained, unnecessary and discriminatory regulation of clinics that perform first-trimester abortions has a severe impact on women's reproductive health and is particularly

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154. RACHEL K. JONES, LAWRENCE B. FINER & SUSHEELA SINGH, CHARACTERISTICS OF U.S. ABORTION PATIENTS, 2008, at 8 (2010), http://www.guttmacher.org/pubs/US-Abortion-Patients.pdf.

155. VA. ABORTION FACTS, *supra* note 153, at 1.

156. *See id.* at 1 (noting that 69% of U.S. women who procure an abortion are "economically disadvantaged").

157. *Id.* at 2.

158. *Id.*

159. *See* Adelman, *supra* note 3 (arguing that TRAP laws were designed not to make abortions safer but rather to limit access to abortions in Virginia).

160. *See* VA. ABORTION FACTS, *supra* note 153, at 1 (noting that 69% of U.S. women who procure an abortion are "economically disadvantaged").

161. *See* VA. CODE ANN. § 18.2-76(B) (West 2012) (requiring delivery of an ultrasound image to the mother at least twenty-four hours prior to performing an abortion).

162. *See* Adelman, *supra* note 3 (arguing that the purpose of TRAP laws is to prevent women from obtaining abortions).

dangerous to low-income women.[163] Advocates in Virginia must use every tool available to reverse the state's TRAP regulations and protect access to reproductive health care.

Thanks to the flawed regulatory process described above, the Virginia TRAP regulations are uniquely susceptible to state court litigation, which has already commenced.[164] A case brought by the Falls Church Medical Center alleges that the TRAP laws violate state law by, *inter alia*, failing to conform to recognized health care standards; arbitrarily imposing greater burdens on facilities that perform abortions than comparable health care facilities; failing to mitigate the costs to small businesses; and applying FGI Guidelines to existing facilities in a manner inconsistent with the Guidelines themselves.[165] The case has already survived a motion to dismiss.[166]

In parallel with litigation efforts, advocates must engage in vigorous public education efforts to reframe the conversation on abortion, and particularly first-trimester abortion, so people understand it to be routine health care.[167]

Public education and advocacy undertaken throughout the two-year regulatory process has already born fruit. In tandem with doctors' widespread opposition, Virginia's residents responded to the new rules for women's health care providers with 81% opposition to the regulations in the online public comment forum on TRAP,[168] and a statewide poll showed that a majority of Virginians (58%), across demographic groups and across self-identified partisanship allegiance, opposed the new

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163. *See* VA. ABORTION FACTS, *supra* note 153, at 2 (noting that public funding is available only in cases of life endangerment, rape, incest, or fetal impairment).

164. *See* Falls Church Med. Ctr. v. Va. Bd. of Health, No. CL 13001362-00 (Va. Cir. Ct. June 10, 2013) (challenging the validity of the TRAP regulations).

165. *See id.* (challenging the validity of the TRAP regulations).

166. *See id.* (setting the trial date for April 29, 2014).

167. *See* SAFETY OF ABORTION, *supra* note 127, at 1 (comparing the dangers of illegal abortion to the safety of legal abortion).

168. *See* VA. REGULATORY TOWN HALL, FINAL REGULATION AGENCY BACKGROUND DOCUMENT 19 (2013), http://www.vdh.state.va.us/administration/meetings/documents/2013/pdf/Agenda%20to%20be%20posted.pdf (noting that 3,379 people submitted comments opposing the regulation and arguing that the regulations should be based on medical need rather than politics).

regulations of women's health care centers.[169] Three-quarters of Virginians (75%) agreed that private medical decisions should be made by women, their families, and doctors—not politicians in Richmond.[170] Proponents of women's reproductive health must build on these early successes to achieve a legislative or administrative repeal of Virginia's TRAP.

## *VIII. Conclusion*

Through targeted regulation of abortion providers, abortion opponents seek to chip away at the constitutional right to reproductive choice by imposing onerous and costly requirements on health care facilities that perform first-trimester abortions.[171] In Virginia, manipulation of the regulatory process by political actors has caused regulators to disregard medical experts in favor of ideological ends.[172] The discriminatory, unnecessary, and onerous architectural standards placed on first-trimester abortion providers in Virginia have already been cited as shuttering one clinic, and more clinic closures may follow.[173] Decreased access to abortion will undermine women's choice and will disproportionately harm low-income women.[174] In order to ensure that providers of first-trimester abortions are not treated disparately from doctor's offices and outpatient medical facilities providing medically comparable services and procedures, advocates must redouble their efforts to ensure that abortion is perceived as part of the total array of comprehensive reproductive healthcare services that women need and have access to.

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169. Memorandum from Beck Research to Interested Parties 1 (Mar. 20, 2013), http://www.coalitionforwomenshealth.org/assets/bin/Virginia%20Women%5C%27s%20Health%20Care%20Survey%20--%20Executive%20Summary%20%283-15-13%29.pdf.

170. *Id.*

171. *See* Adelman, *supra* note 3 (arguing that the purpose of TRAP laws is to limit access to abortion in Virginia).

172. *See* Press Release, *supra* note 33 (noting the attorney general's involvement in the promulgation of the TRAP regulations).

173. *See* Jeter, *supra* note 3 (noting that the Hillcrest Clinic decided to close its doors rather than comply with the costly regulations).

174. *See* VA. ABORTION FACTS, *supra* note 153, at 1 (noting that 69% of U.S. women who procure an abortion are "economically disadvantaged").