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Policy making at the margins: the modern politics of abortion

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POLICY MAKING AT THE MARGINS: THE MODERN POLITICS OF ABORTION

by

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PH.D. THESIS

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ABSTRACT

Scholars often argue that republican government works because elected representatives adopt policies favored by their constituents. Theoretically, this relationship is stronger with morality issues because such issues are technically simple, involve core values, and thus foster greater levels of citizen engagement. Since the U.S. Supreme Court cases of *Casey* and *Webster*, state legislatures have passed hundreds of policies that place cumulatively significant restrictions on women's access to abortion. The increasingly conservative nature of abortion policy might indicate an increasingly conservative electorate, but public opinion on abortion has remained stable since the 1970s with most Americans favoring legal abortion with some restrictions. This is the motivating question of my dissertation—why are states increasing abortion restrictions in the absence of public demand?

Previous research on abortion policy in the states has generally focused on specific policies at specific years. Studying a single policy at discrete moments in time carries an implicit assumption that the determinants of policy are constant. In order to better state abortion conservatism, I comprehensively examine the formation of state abortion policy in the different stages of policymaking, across policy types, and over time.

I find that the stages of the policy making process invokes different incentives for legislators, and as a result, the determinants of abortion policy at each stage of policymaking are different. Despite obvious differences across policy stages, I find a

common theme: legislators create abortion policy in strategic ways, at the margins of the policy making arena, and excluding the preferences of the mass public. In the first empirical chapter, I focus on the agenda setting stage of policy making. Using an original dataset of all abortion-related bills introduced in the states from 2000-2010, I find that the predictors of sponsorship varies across legislator gender and party types. Additionally, I find that the effect of citizen ideology and interest group contributions varies across legislators. In the second empirical chapter, I study the diffusion of nearly 40 pro- and anti-abortion rights policies across the states. I establish a set of average predictors of state policy adoption and show how the effect of partisan actors varies across the policies. In the final empirical chapter, I develop a theory of bureaucratic activism. I use the cases of telemedicine abortion bans in Iowa, insurance bans in Georgia, and clinic regulations in Virginia to show how state bureaucracies take advantage of the broad authority granted to them to enact policy change unprompted by the legislature.

PUBLIC ABSTRACT

Scholars often argue that republican government works because elected representatives adopt policies favored by their constituents. Since the U.S. Supreme Court cases of *Casey* and *Webster*, state legislatures have passed hundreds of policies that place cumulatively significant restrictions on women's access to abortion. However, the increase in conservative policy has not been accompanied by an increase in conservative public opinion about abortion. My dissertation addresses this question —why are states increasing abortion restrictions in the absence of public demand?

I comprehensively examine the formation of state abortion policy in the different stages of policymaking, across policy types, and over time. Despite obvious differences across policies and policy stages, I find a common theme: legislators create abortion policy in strategic ways, at the margins of the policy making arena, and sometimes excluding the preferences of the mass public. In the first empirical chapter, I focus on bill introductions in state legislatures. I find that the predictors of sponsorship vary across legislator gender and party types. In the second empirical chapter, I study the spread of pro- and anti-abortion rights policies across the states. I show which factors predict policy adoption on average and how the effect of some variables changes based on the policy. In the final empirical chapter, I develop a theory of bureaucratic activism. I use three case studies to show how state bureaucracies take advantage of the broad authority granted to them to enact policy change unprompted by the legislature.

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INTRODUCTION

A significant body of political science research argues that republican government works because elected representatives adopt policies favored by their constituents. Erikson, Wright and McIver (1993) conclude, "state opinion is virtually the only cause of the net ideological tendency of policy in the states" (81). Their conclusion is backed by a substantial body of research that presents compelling evidence of policy responsiveness (Page and Shapiro 1983; MacKuen, Erikson and Stimson 1989), even in the absence of congressional turnover (Bartels 1991). Scholars have also established the relationship between policy specific measures of opinion and associated policies (such as Brace et al. 2002; Norrander 2001). Burstein (2003) asserts that "No one believes that public opinion always determines public policy; few believe it never does" (29).

According to the morality politics literature, the relationship between policies and public opinion on issues of morality is especially strong because moral issues involve core values, are technically simple and garner high levels of citizen engagement. Since the Supreme Court decisions of *Planned Parenthood v. Casey* (1992) and *Webster v. Reproductive Health Services* (1989), the anti-abortion rights movement successfully oversaw the passage of hundreds of incremental policies that cumulatively place significant restrictions on women's access to abortion. The goal of anti-abortion activists is now to regulate abortion out of existence without explicitly banning it. One might expect that the increasing conservatism of abortion policy is the result of an electorate that is developing more conservative attitudes towards abortion. Yet, public opinion on abortion has remained stable since the 1970s, with most Americans favoring legal abortion with some restrictions.

Mass public opinion is only important insofar as the electorate is attentive

and active on a given topic. In the words of V.O. Key (1949), "the blunt truth is that politicians and officials are under no compulsion to pay much heed to classes and groups of citizens that do not vote" (527). Given that most abortion policy is technical, seemingly incremental, framed as regulation and low in salience, there is a permissive policy environment around the issue of abortion abortion policy wherein the public is not sure of the relationship between current and proposed policy, and their own preferences relative to the status quo. As a result, the public is only able to express its preferences towards abortion generally, and is less assertive about specific policy. With an inattentive and unaware public, opinion does little to constrain the actions of elite actors, organized interests and the bureaucracy.

Extant studies of abortion policy leave several unresolved questions, particularly in regard to the role of mass and elite opinion, organized interests and the bureaucracy. While the influence of organized interests and the bureaucracy on state abortion policy are well established outside of academia, political scientists rarely give them more than a passing glance. This project addresses several lingering puzzles in the literature. First, the relationship between public opinion and abortion policy warrants closer examination. Studies of abortion policy congruence use fixed measures of state public opinion and find mixed results. Using a time varying measures of state opinion sheds light on the conditions under which public opinion matter. Second, existing research on abortion policy fails to capture the influence of important extra-legislative actors. Interest groups actively lobby politicians and create model legislation, yet few scholars establish a relationship between interest groups and abortion policy. Additionally, the bureaucracy plays an important role in both implementing policy and passing regulations that act as law - yet neither of these roles have been the subject of systematic study. Finally, because the determinants of policy vary across the type of policy and the stage of the policy process, a comprehensive analysis of abortion policy must study these different cases. Taking a closer look

at these three questions will help to explain when and how public opinion matters; and in doing so, will resolve the puzzle of state abortion policy adoption.

1.1 Boom in Abortion Policy

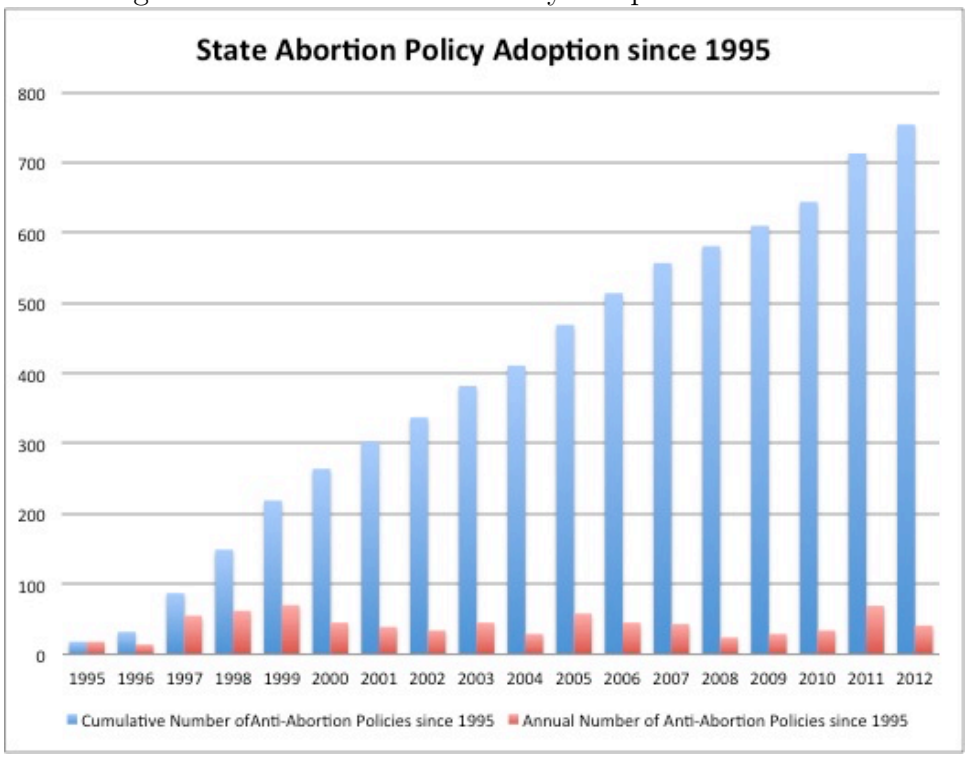
Since the early 1990s, the number of state laws that place restrictions on abortion has grown rapidly. There has been an unprecedented wave of anti-abortion policies, with more restrictive abortion policies enacted from 2011 to 2013 than the previous decade (Boonstra and Nash 2014). The adoption of legislation that expands or protects existing access to abortion is also increasing, albeit at a much slower rate than restrictive policies (NARAL Annual Report 2012). These policies regulate abortion in a variety of ways and the scope, saliency, and technicality of these policies vary accordingly.

After the *Casey* Supreme Court ruling and the subsequent 1994 mid-term election, the anti-abortion movement embraced a strategy of "bold incrementalism" (Rose 2007, 9). Anti-abortion activists pushed for the passage of restrictions that in isolation seem benign but in combination with other restrictions and administrative hurdles place an increasingly large burden on women seeking abortions. Additionally, activists target low salience or highly technical policies that are less likely to trigger the widespread debate exemplified by policies that regulate legal abortion more directly.[1] With this shift in strategy, the objective of abortion restrictions moved away from making abortion illegal (either through a constitutional amendment or the reversal of *Roe*), to making abortion practically unavailable for most women. This strategy of "legal but inaccessible" has resulted in the adoption of a plethora of restrictive abortion policy. More than 700 of these state laws have passed since the

[1]According to Dorinda Bordlee, staff counsel for Americans United for Life, [after the *Casey* decision] "there had to be a shift in strategy by regulation on the outskirts of abortion." Barry Yeoman, "The Quiet War on Abortion," Mother Jones, September/October 2001,http://www.motherjones.com/politics/2001/09/quiet-war-abortion/.

early 1990s (see Figure 1.1).

Figure 1.1: State Abortion Policy Adoptions since 1995



1.2 The Constitutional Context Surrounding Abortion Legality Today

Significant abortion policy shifts are the result of Supreme Court cases. The constitutionality of abortion regulation has varied since 1973, with several important Supreme Court cases setting the standards cases must meet in order to pass constitutional review. Prior to *Roe v. Wade* (1973), state abortion policy varied greatly and many states were liberalizing their policy.

In *Roe*, the Court heard a challenge of a Texas law that made virtually all abortions illegal except to save the pregnant woman's life. The *Roe* decision stated that woman's right to decide whether or not to terminate a pregnancy is part of the

penumbra of privacy rights articulated in the case of *Griswold v. Connecticut* (1965). Writing for the majority, Justice Harry Blackmun concluded that the Constitution's several references to "person" reflect an assumption that people have been born. He wrote that abortion is a fundamental right, but one that a woman cannot make on her own; it is must be made in consultation with her physician. As a fundamental right, abortion restrictions required strict scrutiny on the government's compelling reason for interference. Additionally, he argued that the right to privacy does not extend to all abortions. He acknowledged that at some point in a pregnancy, Western civilization valued the potential human life. He invoked the concept of viability as a compromise between an individual's right to privacy and the state's interest in human life.

Blackmun articulated a trimester rubric to guide the Court in future cases. In the first trimester of pregnancy, a woman may obtain an abortion in consultation with her physician, free from state constraints. In the second trimester, restrictions to abortion access would be permissible only when necessary to protect the woman's health. Finally, in the third trimester, approximately the time at which the fetus reaches a stage of viability,[2] the state could invoke its interest in protecting the life of the fetus and could restrict abortion entirely, except when the mother's life or health is at risk. The Court quickly clarified that abortion did not constitute a constitutional right in a cases such as *Maher v. Roe* (1977) and *Harris v. McRae* (1980), which concerned the rights of poor women to obtain abortions. The Court ruled in *Colautti v. Franklin* (1979) that the viability of a fetus varied across pregnancies, and that viability must be determined by a physician on a case-by-case basis. For a partial list of Supreme Court cases concerning abortion, see Tables 1.1 and 1.2.

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[2]In the early 1970s, fetuses were not considered viable before 28 weeks and less than 1000 grams. State statutes defining viability range from 19 to 28 weeks. http://pediatrics.aappublications.org/content/128/6/1047/T1.expansion.html

The landmark case of *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992) once again shifted the political context around abortion. *Casey* rejects the trimester framework but maintains the emphasis on viability. Without the trimester distinction, the point of viability is no longer fixed; it becomes earlier with technological advances. A new test for "undue burden" (defined as "substantial obstacle") was also established that differed from the one established in *Webster* (previously, "absolute obstacles or severe limitations"). The shift to unburden is importance because of the difficulty in knowing what *exactly* constitutes an undue burden. With the shift from "strict scrutiny" in *Roe* to the lower standard of "undue burden" established in *Webster* and *Casey*, the burden of proof on those challenging abortion laws has also shifted. The government once needed to justify the infringement to individuals, but after these cases *individuals* need to establish a case for substantial obstacles. This is problematic because regulations that seem relatively harmless from a judicial perspective may in the "real world" pose significant challenges; yet the women most affected by regulations may be less capable of mounting a legal challenge.

Since 1973, abortion has been the subject of more than 25 U.S. Supreme Court decisions (for a partial list, see Tables 1.1 and 1.2). Because most of the decisions have applied narrowly to specific policies (and often specific parts of policy), the constitutional context at a given time may vary. Once the Court issues a decision, states generally adopt modified versions of a similar policy to comply with or challenge the Court decision (Patton 2007, Marty and Pieklo 2013).

Today, the Supreme Court is faces the consequences of the *Casey* decision and the unclear undue burden standard. The Court is likely to address the issue of abortion in the near future given contradictory rulings among and within federal circuits. Federal courts have produced different rulings on ultrasound requirements, 20-week gestational bans, and restrictions on medical abortions. Cases with similar

laws have even gotten differing rulings within the same circuit. For example, the U.S. Court of Appeals for the 5th Circuit upheld an admitting privileges requirement in Texas (HB 2) but a different panel in the same circuit blocked a similar law in Mississippi (HB 1390). In the Texas case, the court ruled that because the number of abortion clinics was declining before the law?s enactment and women already had to drive substantial distances to obtain an abortion, the law's effect of closing additional clinics did not constitute an undue burden. In contrast, the Mississippi law threatened to close the state's only abortion clinic, which was an undue burden. Writing for the majority, Judge E. Grady Jolly responded to the state's argument that women could travel to Tennessee, Louisiana or Alabama for the purpose of obtaining an abortion by stating that "Mississippi may not shift its obligation to respect the constitutional rights of its citizen to another state."

1.3 Looking Ahead

The preponderance of previous research on state abortion policy studies only a few specific policies at a single point in time. This scholarship focuses on the congruence of public opinion with policy or the role of partisan women in blocking conservative abortion policy. While there is some truth to these explanations, these common narratives of abortion policy fail to explain why abortion policy is increasingly conservative, why states adopt one *type* of abortion policy over an alternative and how legislators act strategically to further an abortion agenda.

In this dissertation, I build a comprehensive theory of abortion policy. I argue that abortion policy is created in the "margins" of the typical policy process. In this explanation, the influence of public opinion is secondary relative to the preferences of elite actors with abortion agendas and interest groups. I show that the determinants of abortion policy vary across stages of the policy process. As a result, strategic legislators pursue policymaking in different legislative arenas to achieve their policy

goals.

In the following chapter, I apply existing theories to the case of abortion before developing a theory of policymaking in the margins. In the first empirical chapter, I focus on the agenda setting stage of policy making. Using an original dataset of all abortion-related bills introduced in the states from 2000-2010, I find that the predictors of sponsorship varies across legislator gender and party types. Additionally, I find that the effect of citizen ideology and interest group contributions varies across legislators. For instance, interest group contributions increase the likelihood that male legislators introduce conservative abortion policy. In the second empirical chapter, I study the diffusion of nearly 40 pro- and anti-abortion rights policies across the states. I establish a set of average predictors of state policy adoption and show how the effect of partisan actors varies across the policies. For example, Democratic women do not influence liberal abortion policy, and only block certain anti-abortion rights policy. In the final empirical chapter, I develop a theory of bureaucratic activism. I use the cases of telemedicine abortion bans in Iowa, insurance bans in Georgia, and clinic regulations in Virginia to show how state bureaucracies take advantage of the broad authority granted to them to enact policy change unprompted by the legislature. In these states, bureaucrats and the executive enact policy through state health boards after facing repeated failures in the state legislature.

Table 1.1: Select Supreme Court Cases from *Roe* to *Thornburgh*

Year	Case	Major Implications
1973	*Doe v. Bolton*	Struck down state residency requirement, and requirement that abortions be performed in specially accredited hospitals
1975	*Bigelow v. Virginia*	Permitted advertisements for legal abortion
1975	*Connecticut v. Menillo*	Permitted states to require that abortions be performed by physicians
1976	*Planned Parenthood of Central Missouri v. Danford*	Upheld legal right to abortion; struck down written parental consent requirement for minors and spousal consent for married women; upheld reporting requirements; struck down a ban on saline injection abortions; stated that fetal viability varied with each pregnancy and must be determined by the physician
1977	*Maher v. Roe*	Upheld a state's refusal to use Medicaid funds for nontherapeutic abortions was constitutional
1979	*Colautti v. Franklin*	Ruled that the determination of viability must be on a case-by-case basis.
1979	*Bellotti v. Baird*	Struck down requirement for parental consent unless a confidential alternative was provided
1980	*Harris v. McRae*	Upheld the Hyde Amendment, restricting use of federal Medicaid funds for abortions to medically necessary abortions
1980	*Williams v. Zbaraz*	Ruled that states do not have to pay for medically necessary abortions for Medicaid eligible women
1981	*H.L. v. Matheson*	Allowed states to require parental notification of abortion for an immature and unemancipated minor
1983	*City of Akron v. Akron Center for Reproductive Health*	Struck down 24-hour waiting period and informed consent rules, parental or judicial consent for all minors, and all hospitalization for all second-trimester abortions
1986	*Thornburgh v. American College of Obstetrics and Gynecology*	Struck down informed consent rules and standards of care for post-viability abortions

Table 1.2: Select Supreme Court Cases from *Webster* to *McCullen*

Year	Case	Major Implications
1989	*Webster v. Reproductive Health Services*	Upheld a state's right to prohibit state-employed physicians and state-facilities from conducting abortions; upheld required viability testing
1990	*Hodgson v. Minnesota*	Upheld notification of both biological parents of a minor's abortion if judicial bypass is provided, and a 48-hour waiting period for minor women
1990	*Ohio v. Akron Center for Reproductive Health*	Upheld one-parent notification if judicial bypasses are provided; ruled that states need not guarantee absolute anonymity for minor's; upheld more difficult standard of proof for minors seeking bypass.
1992	*Planned Parenthood of Southeastern Pennsylvania v. Casey*	Replaced the trimester framework with "undue burden" standard; upheld a 24-hour waiting period, informed consent rules, reporting requirements, and consent of one parent or judge for minor's abortion; stuck down partner notification
1994	*Madsen v. Women's Health Center*	Ruled that some court-ordered restrictions on abortion clinic demonstrations are constitutional
1997	*Schenck v. Pro-Choice Network of Western New York*	Struck down a floating bubble zone around patients and vehicles entering and leaving an abortion clinic.
2000	*Hill v. Colorado*	Upheld 8-foot "no approach" zone for protestors within 100 feet of abortion clinics
2000	*Stenberg v. Carhart*	Struck down state law restricting the Intact Dilation and Extraction procedure (commonly known by the political name "partial birth abortion") because it lacked a health exemption
2007	*Gonzalez v. Carhart*	Upheld a federal law restricting the Intact Dilation and Extraction procedure (commonly known by the political name "partial birth abortion")
2014	*McCullen v. Coakley*	Struck down a 35-feet fixed buffer zone because it violated First Amendment speech too broadly

CHAPTER 2
POLICYMAKING AT THE MARGINS OF THE POLICY PROCESS

2.1 Explaining Abortion Policy: Applying Existing Policy Theory

2.1.1 Incrementalism

Early students of public policy making argued that the political posturing and risk avoidance exhibited by policymakers results in incrementalism. By this, they meant that policy change occurs slowly, through the adoption of many policies that slightly shift the status quo in a certain direction (Lindbloom 1968). Combined together, the accumulation of many policies with subtle policy shifts in one direction can result in substantial policy change.

At first blush, the theory of policy incrementalism appears to fit the case of abortion policy. After the Supreme Court case *Roe* the goal of anti-abortion activists was to eliminate legal abortion. However, since the Supreme Court decisions of *Casey* and *Webster* the anti-abortion rights movement has explicitly sought a strategy of incrementalism with the goal of making abortion legal but inaccessible.[1][2]

Empirical evidence from Congress and state legislatures provide evidence of incrementalism. Ainsworth and Hall (2011) argue that members of Congress pursue "strategic incrementalism" in the area of abortion policy in trying to find a balance between vote maximization and policy gains. Rose (2004) refers to state abortion policymaking in state legislatures as following a pattern of "bold incrementalism"

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[1] In 1992 Mark Crutcher, the founder of Life Dynamics said,"We have opportunities before us which if properly exploited could result in an America where abortion may be perfectly legal, but no one can get one" (Clarkson 1997, 171).

[2] According to the prominent anti-abortion news source LiveAction,"*Roe v. Wade* mandates that abortion be legal. It does not require that abortion be accessible. Pro-life legislators . . . have recognized the distinction between these two statements and are using it to end abortion in their state. But not by making abortion illegal - by making it virtually inaccessible." (Miladin 2012)

characterized by hundreds of policies that significantly restrict abortion access. Many of these policies follow an incremental trajectory. States often adopt bans on abortion that set increasingly lower week limits. Many states have upper limits for gestational age of the fetus (most commonly 24 weeks after the last menstrual period), but recently 8 states have lowered the upper limit to 20 weeks, and one state to 18 weeks.[3]

However, in other ways, incrementalism fits the case of abortion poorly. While some of the policies adopted in the last few years have been incremental, many result in significant policy shifts. In state legislatures, non-incremental policy change is evident in many examples, such as personhood bills that would ban all forms of hormonal birth control, early-term abortion bans that would ban many first-trimester abortions, mandatory waiting periods of several days, etc. The non-incremental nature of abortion policy is also evident in the closing of abortion clinics. The number of abortion providers has been decreasingly steadily since the early 1980s (Jones and Kooistra 2011).

2.1.2 Multiple Streams and Punctuated Equilibrium

Scholars argue that policymakers and policy entrepreneurs use incrementalism in order to achieve their preferred policies. Policy entrepreneurs are a broad category of people in and outside of government, in elected or appointed positions, in interest groups or research organizations (Kingdon 1984, 122). Kingdon (1984) views the policy formation process as being composed of three streams: a stream of problems and problem definitions, which he calls "problems"; a stream of solutions to problems, called "policy"; and a stream of elections and elected officials, called "politics." These streams usually operate independently of each other. When pol-

[3] 18 states have unconstitutional and unenforceable bans on abortions as early as 12 weeks.

icy windows open, entrepreneurs couple the streams to promote significant policy change. Policy windows may open because of a "focusing event"; such as a disaster, crisis, personal experience, or powerful symbol that draws people's attention to issues related to the event. Policy windows open and close very quickly, so entrepreneurs act quickly to merge existing problems and solutions. Once a policy window closes, significant policy change is unlikely. According to this theory, policy entrepreneurs play a crucial role in catching the attention of policymakers and manipulating the policy debate to their preferences, often working across state lines (Kirst, Meister and Rowley 1984, Mintrom 1994 and Walker 1981). Entrepreneurs do this through framing, priming, and the use of symbols. These often involve emotional or cognitive appeals that change the dynamics of the debate by highlighting different facets of a problem. When a policy window is closed, entrepreneurs may employ "salami tactics" - proposing policy change in distinct steps instead of significant policy change in order to reduce the "risk" to policymakers (Sabatier 2007, 77). In other words, the theory predicts incrementalism (salami tactics) with rapid and significant policy change when policy windows briefly open. In the case of abortion, policy windows open and close after events such as court cases, clinic bombings, and media portrayals of abortion.

This theory is appealing in that it applies to existing policy debates to explain policy change. Yet, this theory is also problematic because the hypothesized mechanism is not easily studied. Sabatier (1999, note 5) critiques the Multiple Streams framework for making unrealistic assumptions, for under-specifying casual processes, and failing to generate clear and falsifiable hypotheses. It is difficult to quantitatively evaluate the mechanisms of this theory.

The Punctuated Equilibrium framework theorizes a similar pattern of policy adoption to explain significant policy change. Baumgartner and Jones (1993) argue that policymaking in the U.S. is characterized by long periods of incremental change

("near stasis") punctuated by brief periods of significant policy change. In periods of equilibrium, a single policy subsystem dominates the issue framing (or policy image). A policy monopoly has a definable institutional structure responsible for policymaking in an issue area. The monopoly legitimizes its control over policymaking with a powerful policy image. In disequilibrium, the issue reaches the broader policy agenda: new policy images emerge that attract new participants and institutions, who in turn write new "rules" that are institutionalized and affect future policy change.

Central to both of these theories is the idea that a change in the issue framing, use of symbols, or policy image precipitates significant policy change. A clear example of this type of framing change in abortion policy is the case of the Intact Dilation and Extraction (IDE) procedure. After a physician presented a paper at conference held by the National Abortion Federation in 1995 on this new procedure to terminate late-term abortions, the National Right to Life Committee (NRLC) commissioned drawings, booklets and paid advertisements to bolster public opposition. Douglas Johnson, a lobbyist for the NRLC, worked to popularize the political term "partial-birth abortion" in the hopes that once the "public learns what a 'partial-birth abortion' is, they might also learn something about other abortion methods, and that this would foster a growing opposition to abortion" (Rovner 2006). Republicans introduced a bill in Congress shortly after the conference using the phrase "partial birth abortion" and similar bills in state legislators followed.

Before the politicization of this procedure by the NRLC, the procedure was virtually unknown to the public and thus there was no clear policy image. Pro-abortion rights groups, such as NARAL, have tried to change the policy image again with limited success by emphasizing that the procedure is extremely rare and the safest way to terminate certain late-abortions. In their own documentation, NARAL refers to this procedure as "certain safe, medically appropriate abortion services often necessary to protect a woman's health as early as the 12th week of pregnancy"

(NARAL Who Decides, 2103).

The pattern of abortion policy adoption is not entirely inconsistent with the punctuated equilibrium or multiple streams frameworks. Significant events such as Supreme Court cases do result in abrupt and substantial change in policy (Patton 2007, Rose 2004 and others). However, these significant events are not always associated with changes in the subsystems of support or in the policy images. Moreover, abortion policy is not in equilibrium - it is steadily moving in a non-incremental, conservative direction. When significant policy change has occurred, it has not been after the Supreme Court changed the standards for what types of policy are constitutional. Instead, the most rapid adoption of policy has been in the last few years —some 15-20 years after the latest landmark Supreme Court case (*Casey* was in 1992) (see Figure 1.1).

2.1.3 Morality Policy

Some scholars argue that the relationship between public opinion and morality policy is especially strong. Morality policies[4] can be defined as ones in which "at least one advocacy coalition involved has portrayed the issue as one of morality or sin and used moral arguments in its policy advocacy" (Haider-Markel and Meier 1996, 333). The policies also "seek to redistribute values and to put the government's stamp of approval on one set of values and to abuse another" and to change behavior (Meier 2001, 21). "Moral entrepreneurs" translate social anxieties and negative perceptions of marginal groups into "legislative crusades" that convince others that action is needed to punish sinners (Nicholson-Crotty and Meier 2005).

Mooney (2001) lays out a consensus about morality policies. They are 1)

[4]Abortion is often considered a quintessential "morality issue" in political science, along with the death penalty (Mooney and Lee 1999), sodomy laws (Nice 1988), physician assisted suicide (Glick and Hutchinson 2001), drug policy (Meier 1994), gambling (Morgan and Meier 1980), and same-sex marriage (Haider-Markel and Meier 1996).

technically simple and everyone can legitimately claim to be well informed; 2) they are conflicts of core values, are highly salient to the public and unlikely to change; and 3) because citizens are well informed and the issues are salient, there is a higher than normal level of citizen participation (7-8). Because of these characteristics, policy makers are more responsive to public opinion on morality issues and the role of elites is limited to the extent and timing of the adoption that the public supports. The debate over abortion is unlikely to be resolved in the near future because both sides frame the issue with "first principles." Kristin Luker (1984) suggests that pro- and anti-abortion activists live in fundamentally different social worlds with substantially different perspectives on a range of issues such as motherhood and traditional gender roles. The stakes are high for both sides of the issue - if the "other side" were to win, one group would feel a "real devaluation of their lives and life resources." (Luker 1984, 215).

In all major surveys since the legalization of abortion, support for legal abortion has remained relatively stable, although support varies based on a number of factors. A substantial proportion of the electorate does not think abortion should be illegal or legal in all circumstances (Cook, Jelen and Wilcox 1992). Support varies dramatically with the reason a pregnant woman wants an abortion. Long-term trend data from the General Social Survey (GSS) since 1972 shows that support for legal abortion is substantially higher when an abortion is wanted because of concerns for the life/health of the woman, fetal defect, rape or incest (see Figure 2). Justifications for abortions that seem more elective, such as low-income or the woman does not want more children, receive far less support (Rose 2007, 46-7). Support also declines dramatically with gestational age of the fetus. An experiment on the impact of question wording on support for legal abortion found that support for abortion is highly dependent on gestational age of the fetus, with support dropping off rapidly after the first trimester as well as question ordering effects (Bumpass 1997). Public opinion

measured by major polling houses has continued to hold steady in the last few years or liberalized slightly.[5]

Nevertheless, there are good reasons to believe this may not be the case. The findings from this literature leads one to expect that the increasingly conservative state policies can be explained by mass public opinion shifting towards a more conservative perspective. Yet, scholars repeatedly find public opinion on abortion has remained steady (Wetstein 1996; Wilcox and Riches 2002; Pacheco 2014) with a plurality of voters believing abortion should be legal with some restrictions (such as Mouw and Sobal; 2001, Bumpass 1997; Page and Shapiro 1992; Cook, Jelen and Wilcox 1992, Smith 1994).

2.1.4 Representation Policy

The theories of incrementalism, punctuated equilibrium and morality policy largely ignore the political context surrounding policy change. Morality policy theory does explain policy change because of change in demand for the policy or public opinion, but ignores the legislative environment. Only the multiple streams theory explicitly incorporates the legislative environment in the political stream. Because elected politicians make policy, it is useful to briefly consider how partisanship, gender, and religious identities of the members of the legislative chamber shape policy.

Abortion is a very partisan issue today, but this was not always the case. From 1972-1980, there were no significant differences in the attitudes of Republican and Democratic partisans and the national parties did not have distinct platforms on the issue (Carmines and Woods 2002). By the end of the 1980s, over 80% of Democrats voted in favor of abortion rights and 80% of Republicans opposed abortion

[5]For example, Gallup (http://www.gallup.com/poll/1576/abortion.aspx) shows public opinion holding stead, but Pew (http://features.pewforum.org/abortion-slideshow/) shows a liberalization of public opinion.

rights (Adams 1997). Around this same time, the constitutional context surrounding abortion changed in *Casey* and *Webster*.

Because the parties have distinct platforms on the issue of abortion, party control of the state government may play a significant role in shaping state abortion policy. Partisan control of the legislative and executive branches may affect policy due to party control over the agenda and party discipline (Aldrich and Rhode 2001). Incremental pro- and anti-abortion policies are less likely when Republicans are in the majority, and especially when Republicans are more conservative (Ainsworth and Hall 2011). This influence may be more significant after 1989, when the constitutional context changed and the parties became more polarized on abortion.

Attributes of individual legislators, such as gender and religion, are also important. Building off theories of critical mass (Thomas 1990), many scholars find that as the presence of more elected women results in the adoption of more women-friendly policies. This relationship is particularly strong on the issue of abortion when looking at the intersection of partisan and descriptive representation (Hansen 1993; Tatalovich and Sheier 1993; Medoff 2002; Norrander and Wilcox 2001; Caiazza 2004). However, these findings are not universal. The effect of Democratic women on abortion policies may be limited to only certain policies (Berkman and O'Connor 1993, Cowell-Meyers and Langbein 2009). Religious identification correlates with legislator's opinion on legal abortion (Tatalovich and Sheier 1993, Ainsworth and Hall 2011) and on whether the legislator supports incremental or substantial policy change (Ainsworth and Hall 2011).

The partisan and gender dynamics of state legislatures are among the strongest determinants of state abortion policy, but these theories also fail to explain the pattern of abortion policy making. The presence of women in state legislatures has increased dramatically over time. Today, women?s representation in state legislatures is at record levels. Based on the increasing presence of women in state legislatures, espe-

cially Democratic women, abortion policy ought to be moving in a liberal direction.

2.2 Reconsidering the Determinants of Abortion Policy

The question of abortion policy in the states is undergoing significant change despite conditions that would predict otherwise (such as unchanging public opinion or more women in the legislature) is unresolved. Previous work on abortion policy established the role of descriptive and partisan representation and policy-specific characteristics, but work on the role of public opinion and organized interests find very mixed results. In this section, I discuss how we ought to measure and re-conceptualize public opinion on abortion, interest groups and the bureaucracy, and the importance of looking at the effect of these variables across time and a variety of abortion policies.

2.2.1 Incorporating a Nuanced Understanding of When Public Opinion Matters

Due to the significant disconnect between public opinion over time and the adoption of specific abortion policies, theories of morality policy cannot fully explain the proliferation of abortion policy. One reason that mass opinion on abortion has changed little over time may be that it is an easy issue for people with low-sophistication. According to Carmines and Stimson (1980), there are some issues are on which even people with low sophistication can form an opinion because the issue has "become so ingrained over a long period that it structures voter's gut responses? to candidates and political parties" (78). Abortion, and morality policies more generally, are classic "easy" issues because they generate intense emotional reactions and seem highly salient to government officials, activists and interest groups (Carmines and Stimson 1989; Layman and Carsey 2006). Abortion also appears to be an easy issue when looking at the low "non-response" rate on NES studies over time, even among voters with low political sophistication (Cizmar and Layman 2009). Respondents have consistent answers on abortion issues, and these responses are unaffected

by slight variation in question wording or question order.

Variation in Abortion Opinion

Public opinion on abortion at the aggregate national level has remained stable over time, but there may be important changes in state-level public opinion over time. Most scholars rely on measures of state-level public opinion are based on polls in specific time periods. This may not be a significant problem considering the substantial evidence that abortion opinion at the national level has remained relatively flat over time (Wetstein 1996; Norrander and Wilcox 2001; Wilcox and Riches 2002; Jelen and Wilcox 2003). Pacheco (2014) created state attitudes toward abortion from 1980-1998 and finds that opinion is stable, with only gradual changes that are homogenous across the states. To date, this is the longest time varying data on state opinion on abortion attitudes.

The opinion of activists and legislators with higher levels of political sophistication has also changed over time. Looking at differences between the parties from 1973-1994, roll call votes and GSS surveys that show widening abortion attitudes among partisans, Adams' (1997) argues that polarization began earlier and was more significant among political elites. This shows evidence of issue evolution (Carmines and Stimson 1989), with elite change in preferences leading to a mass-level response (Erickson, Wright, McIver 1993). Carmines and Wood (2002) add to this debate by looking at the less-studied "missing link" in issue evolution process: party activists (operationalized here as those who self identified in the ANES as an "activist" or were a delegate to a national convention from 1972-1996). They show that party activists are the mechanism through which mass response changes, similar to the process of issue evolution on race. Yet, the process of issue evolution on abortion is incomplete; mass public opinion has remained largely unchanged, even while the opinions of partisans and activists have polarized.

On a given issue, some members of the public are more active and have greater intensity in terms of their preferences. This may be the case for abortion, where activists have more extreme preferences and are more active at expressing their preferences to representatives. Meier (2001) theorizes that while the public?s preferences on abortion represent a normal distribution, activists may have extreme preferences represented by a bimodal distribution. He argues that while there are heterogeneous preferences for morality policy, supporters of the "sin"-side of the issue (in the case of abortion, supporters of legal abortion) may be less likely to be vocal supporters. As a result, legislators often have a skewed perception of public support for a morality policy, believing the median voter has more conservative preferences than represents the true distribution of public preferences. When the public is unaware of a policy debate or not active in asserting their preference, policymakers have more leeway to adopt policies that are consistent with their own preferences.

The Influence of Opinion on Policy

Studies that look specifically at the influence of public opinion on abortion legality and state policy find congruence. States that have policy that is more conservative also have more conservative abortion attitudes, but changes in opinion do not predict changes in policy. Wetstein and Albritton (1995) argue that public opinion leads to a state culture, which in turn affects both the restrictiveness of policy and the incidence of abortion. Abortion policy is also more responsive to public opinion under conditions in which the issue is salient, opinion is stable, interest groups support the public preferences and parties take distinctive positions (Norrander and Wilcox 1999; Norrander 2001) and public opinion about abortion legality is mediated by the preferences of individual legislators and governors (Goggin and Kim 1992).

The degree of variance of public opinion also has implications for policy adoption. Cohen and Barrileaux (1993) find that interest group preferences prevail when

an issue is narrowly decided or slightly leans in one direction, and even half the time when public opinion is at a landslide in the opposite direction. They conclude that the only time opinion consistently supersedes organized interests is when public opinion is nearly consensual on one side of an issue (214). A closely divided public may constrain policy options because the level of conflict garners greater public attention to the issue, but when opinion is unified, policy makers are more likely to follow their own ideological preferences regarding the timing and content of policy change (Mooney and Lee 2000).

Evidence of Low Policy Knowledge

It is important to note that the questions used in public opinion polls that measure attitudes on abortion studies ask about various justifications for abortions (such as economic reasons, health concerns, fetal defect, unwanted child etc.) or the legality of abortion in general terms - and *not* actual policies or regulations. There is little evidence that the mass public actually knows what the abortion policies are in their respective states. This lack of policy awareness may be a crucial missing link that explains the disjuncture between public opinion and abortion policy across time.

Preliminary evidence from a telephone survey conducted by the University of Iowa Hawkeye Poll[6] indicates that abortion policy knowledge among the general public is low and there is only a weak relationship between specific policy preferences and opinion on abortion legality in general. Iowans were asked about what abortion policies are currently in effect in Iowa and which policies the public would prefer to be state policy. Specifically, respondents were asked if Iowa had the following four policies (1) mandatory parental consent or notification, (2) mandatory waiting period, (3) mandatory distribution of literature created by the state government about

[6]The poll was conducted 11/11/13-11/17/13.

abortion (often titled Women's Right to Know act), and (4) ban on telemedicine for non-surgical abortions.[7] At the time of the survey, Iowa had only the first of the four policies in effect. An Iowa Board of Health regulation that forbade telemedicine abortions was in the news just days before the survey. A Polk County District judge suspended the ban the day before it was to go into effect, and just days before the survey took place (for more information about the telemedicine abortion in Iowa, see Chapter 5).

The only policy for which there was a high level of knowledge was mandatory parental consent - a common and relatively non-controversial policy (see Table 2.1).[8] Only about half of the respondents answered correctly regarding mandatory waiting periods and telemedicine abortion bans (though the latter's status was somewhat in limbo), and only 38% of respondents were correct about mandatory literature.

Table 2.1: Correct Abortion Policy Knowledge (Percent)

Policy	In Effect	Democ.	Indepen.	Repub.	Men	Women	Total
Parental Involvement	Yes	70	72	65	71	67	69
Waiting Period	No	51	48	53	47	56	51
Mandatory Literature	No	37	40	34	33	43	38
Telemedicine Ban	No*	46	50	50	50	46	48

The poll asked respondents about their opinion regarding whether or not abortion should be legal in general and if the four policies should be state law. There was

[7]Exact survey wording for the policies was (1) parental consent or parental notification; (2) mandatory waiting period; (3) mandatory distribution of literature created by the state government; (4) allow the distribution of abortion-inducing pills by physicians via video-conferencing.

[8]At the time of the survey, 38 states required parental involvement when a minor women sought an abortion. Of these, 21 states required parental consent only, 12 states require parental notification only, 5 states require both consent and notification, and 8 states require that the parental consent documentation be notarized.

very low correlation between the number of policies a respondent through should be in effect and whether abortion should be legal in general was very low (.13). This indicates that respondents' opinion about abortion general was not strongly related to the respondents support of specific abortion policies.[9] This relatively weak relationship between issue opinion and policy preference gives politicians flexibility when interpreting public preferences into law.

To summarize, there are several lingering questions regarding the relationship between public opinion and abortion policy. First, few polls ask opinions on specific policies and no previous survey has asked respondents what policies their state has in effect. Without that type of question, there is no evidence that constituents are even aware of what policies have been adopted in their state, and thus cannot rationally answer questions about if they want more or less policy. Preliminary evidence from the University of Iowa Hawkeye Poll indicates this is true. Most people do not know which policies are in effect in their state, and their preferences on specific policies are not highly related to their general opinion on abortion. Second, due to previous limitations in available data, it is unknown how state-level opinion on abortion has changed since *Roe* and how the effect of public opinion on policy has changed over time. Finally, few studies look at *when* public opinion on abortion matters. In particular, how is the effect of public opinion conditional on the political context.

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[9]When asked about abortion legality in general, 39.5% of the 975 respondents thought abortion should be legal in all circumstances; 43.3% thought abortion should be legal only in the cases of rape, incest, or life or health of the mother; and 17.2% believed it should be illegal in all circumstances. When asked if specific policies should be state law, 82% supported parental consent, 68% supported a mandatory waiting period, 60% supported literature created by the state government be distributed, and 63.4% supported a ban on telemedicine abortions. On a scale counting how many of the four policies the respondent through should be state law, the average response was 2.5 policies.

2.2.2 Interest Groups Shape Opinion, Set Agendas, and Assist Policymakers

Previous research suggests that interest groups have a substantial impact on public policy. These studies find interest group influence in both specific policy areas (i.e. Haider-Markel and Meier 1996, Nicholson-Crotty and Nicholson-Crotty 2011) and general economic growth (Gray and Lowery 1988). Interest groups can provide representation by advocating on behalf of different groups within society (Dahl 1960). Yet a wealth of evidence undermines these pluralistic ideals. The distribution of interest groups is biased, with elites, business-interests and institutions overrepresented relative to groups that represent citizens' interests (Schattschneider 1975, Schlozman 1984, Scholzman and Tierney 1986, Baumgartner and Leech 2001).[10] This bias is problematic because organized interests determine the agendas of those in power by expanding or minimizing conflict (Schattschneider 1975).

Interest groups may moderate the role of public opinion. While interest groups may be more successful when the group's preferences are similar to the public's preferences (Burnstein 2003), interest group preferences may prevail even when public opinion is in opposition (Cohen and Barrileaux 1993). Despite the evidence suggesting that interest groups influence policy, Burnstein (2003) finds that less that 30% of studies looking at the relationship between opinion and policy take into account interest groups. When interest group activity and public opinion are studied simultaneously, both shape policy (Norrander and Wilcox 2001).

While the public is generally supportive of legal abortion, interest groups are far more opposed. Few people are willing to "stand up for sin" (Meier 2001), which may explain the conservative bias in abortion-related interest groups. Wilcox (1989) counts 85 abortion political action committees (PAC) from 1978-1984, and finds that

[10]Salisbury (1990) and Gray and Lowery (2001) note that bias in the formation of groups does not necessarily mean bias in government outputs.

81 were pro-life and raised 68% of abortion PAC monies.[11] Thus, abortion policy is an interesting policy area where interest groups and public opinion clash.

Organized lobbying interests may be less influential than grassroots pressures from constituents (Norrander and Wilcox 2001). Many scholars use membership records from NARAL to estimate the size of active pro-abortion rights population in the state, but the anti-abortion counterpart (NRLC) does not provide information on membership or newsletter circulation. As a result, scholars tend to use the percent Catholic or evangelical Protestant in the district/state (such as Cohen and Barrileaux 1993; Norrander and Wilcox 2001). The use of religious identification as proxy for the size of interest group support is problematic for several reasons. First, while the Catholic church is firmly opposed to abortion, many Catholics have more pragmatic opinions and evidence suggests they access abortion procedures at a similar rate as other religious groups. Additionally, there is substantial evidence that frequency of attending religious services is a more important predictor of abortion opinion than religious identification. Nevertheless, measures based on the percent of the population that are evangelical Protestant and Catholic are consistently significant in the expected directions, and among the strongest determinants of policy (Meier and McFarlane 1993; Medoff 2002).

Occasionally, individuals or issue-specific groups that act as policy entrepreneurs motivate policy. The policy entrepreneurs who work towards the passage of legislation often drive issue definition and raise awareness of a policy problem or solution. There is little previous research on policy entrepreneurs in the morality policy realm, but this is a fruitful area for future research. Looking at recent innovations in abortion regulation, small groups of individuals have been a driving force in pushing for new

[11]In is unknown how dominant the anti-abortion rights interest groups have been over time. It is likely that each side of the debate becomes stronger at certain points in time, responding to the other group as well as to national events (Meyer and Staggenborg, 2008).

legislation. Since Keith Mason established the anti-abortion group Personhood USA, the group has initiated more than 25 "personhood" bills and ballot initiatives with the margin of loss decreasing with each subsequent election (Marty and Pieklo 2013). These policies would declare that personhood begins the moment of fertilization, and would ban all forms of abortion as well as hormonal birth control. The role of groups such as these is difficult to ascertain - PersonhoodUSA is associated with Pro-Life Super PAC (which spent $13.8 million in 2012 according to OpenSecrets.org) but Faith2Action is not associated with a single interest group. As Mintrom and Norman (2009) argue, the idiosyncratic nature of these actors may necessitate the use of some qualitative methods to study their influence.

The mainstream anti-abortion interest groups do not support these types of bills because they are extreme and risk the Supreme Court setting a precedent to overturn an abortion restriction (Redden 2013). These groups are frequently at odds with mainstream interest groups because they have different objectives. Anti-abortion rights advocates prefer a legislative strategy that chips away at abortion access, pushing for incremental and relatively non-controversial policy change. They often propose changes that limit abortion access where public opinion is lowest, such as banning certain types of non-therapeutic abortions, late-term abortions or increasing regulation. Anti-abortion policy entrepreneurs are more extreme, and actively try to engage the Supreme Court (Reddin 2013), designing bills to convince Justice Anthony Kennedy to overturn *Roe v. Wade* (1973). Groups such as the National Right to Life Committee (NRLC) or the Americans United for Life (AUL) do not support this approach. According to James Bopp, the general counsel to NRLC,

> "If one of these measures ever got to the Supreme Court, which is highly unlikely because they are so obviously unconstitutional under *Roe v. Wade*, it would allow the court to refashion abortion law under, maybe, gender discrimination. Which would mean that all regulations on abortion would be unconstitutional" (Reddin 2013).

While these groups are both opposed to legal abortion, they pursue different strategies that are sometimes in opposition to each other. Therefore, it is imperative scholars find ways to study these groups as separate forces.

To summarize, there are two remaining questions about the role of organized interests and abortion. The role of interest groups in this area is unclear. Some studies have found that interest groups have a greater influence than public opinion, especially when salience is low, but other studies find null results. It is likely that the measurement used for interest groups fails to capture the role of national interest groups or groups originating from other regions on a state's policy. Scholars have measured the effect of interest groups on abortion policy by looking at several measures: the number of registered "women's issue" interest groups in each state (such as Lowery and Gray's measure); the number or amount of donations to abortion PACS in each state above $200 (such as Wilcox (1989) which covers 1978-1984 or Norrander and Wilcox (2001) which covers 1989-1992); or to measure "grassroots" interest groups use the size of Catholic population as a measure for the anti-abortion population and the number of NARAL members to measure pro-abortion rights supporters (Cohen and Barrileaux 1993; Meier and McFarlane 1993; Medoff 2002 and others).

These measures suffer from not being abortion specific, from varying over a short period of time, and from asymmetrically and indirectly measuring grassroots support of interest groups. It is possible that the mixed results regarding the role of interest groups on abortion policy is due to the issues with these measures. Additionally, these measures do not account for the role of policy entrepreneurs or policy-specific PACS (such as PersonhoodUSA's Pro-Life Super PAC), whose role in providing legislative templates and financial support is well documented in news reports. In order to overcome these problems, it is important evaluate the effect of all interest group contributions (not just contributions from the largest ones) and to differentiate between pro- and anti-abortion rights contributions.

2.2.3 The Bureaucracy - An Alternative Venue for Policymaking

Bureaucrats are usually appointed by the governor and not elected by the public. Despite this, bureaucracies can also be an important form of representation. Changes in the bureaucracy can be more important than political events (Eisner and Meier 1990), and agency directors affect policy outputs (Wood 1990). Bureaucratic adoptions are also very common - in the past few decades, federal agencies adopted 10 times as many rules as Congress has passed laws (Conglianese 2004, 5). Who populates the bureaucracy may influence the content of rules established by government agencies. The governor's role in selecting agency heads and board members ensures that the chief executive in the state has substantial influence over who fills these positions. Executives fill positions in the bureaucracy with like-minded individuals, and the partisanship and ideology of the executive influences the race, gender and ideological composition of executive offices. In particular, Democratic executives are more likely to appoint women and minorities (Clark, Ochs, and Frazier 2013).

The composition of the executive offices can influence the policy priorities and preferences of the bureaucracies, and shape policy outcomes. The representative bureaucracy literature posits that a demographically representative bureaucracy will produce policy that reflects the preferences of the populace. Bureaucrats from different race, gender, age, and class groups have meaningfully different life experiences, and bureaucrats bring these diverse perspectives to the agencies they serve. When the bureaucracy has sufficient autonomy and discretion in policy implementation, then the diversity of representation can result in true substantive representation of different demographic groups (Meier and Stewart 1992; Keiser, Wilkins, Meier and Holland 2002; Dolan 2002). Substantive representation is particularly likely when there is a critical mass of descriptively representative people in the agency, and when the agency's purpose relates to a salient issue for the demographic group (Meier 1993,

Thompson 1976). For example, women in the federal bureaucracy advocate more for women's issues when they are part of a department devoted to women's issues (Dolan 2000).

There is relatively less research on how bureaucracies act as partisans. Appointed bureaucrats may act in a partisan way that reflects the partisanship of the elected executive or of the population they serve. For example, several studies find that party affiliation of local officials influences the provisional votes cast and counted (Kimball, Kropf, and Battles 2006; Kropf, Vercellotti and Kimball 2013). This may be because the bureaucrats are acting in such a way as to reassure their reappointment, or they may genuinely feel they are acting on behalf of the people they serve.

Interest groups may also influence the actions of the bureaucracy. Some scholars find that the notice and comment procedure in rulemaking does not systematically favor business interests (such as Cropper et al 1992; Nixon, Howard and DeWitt 2002). However, Yackee and Yackee (2006) evaluate 30 rules from 1994-2001 and find that as the proportion of business commenters increases, the influence of business interests increase as well. Current law requires the federal bureaucracy to be responsive to concerned groups (Kerwin 2003), however, the courts now mandate that commenting be included in the public records used to generate future rules (Funk, Shapiro and Weaver 1997, 93). Therefore, interest groups have a venue through which to exert their preferences to which the bureaucracy is required to be attentive. Other scholars suggest that interest groups may influence the bureaucracy indirectly through working with Congress (McCubbins, Noll and Weingast 1987, Balla and Wright 2001).

Researchers generally study the independence of the bureaucracy by measuring the level of discretion granted to it from the state legislature or by looking at the notice and commenting process. Scholars can measure the level of discretion granted to bureaucrats with the length of legislation (the number of words), with longer statutes providing instructions that are more detailed and hence greater constraints

on bureaucrats and other political actors (Huber and Shipan 2002). The extent to which state legislatures are able to create longer statutes is dependent on several other conditions, such as the political context (whether legislators and agencies agree, partisanship, etc.), the professional capacity of the legislature, and the ways in which the legislature can control the bureaucrats (Huber, Shipan, and Pfahler 2001).

At this time, there is no systematic study of the role of the bureaucracy in implementing abortion policy. The preponderance of research on bureaucracies focuses on the level of the federal government and rarely relating to social policy. More importantly, the previous research focuses on studying how much discretion state legislatures grant to bureaucracies and how the demographic composition of the bureaucracies shapes the policy preferences and outputs of bureaucratic agencies. The previous literature does not evaluate the incentives or conditions under which bureaucracies effectively *create* policy when not directed to do so by the legislature.

2.3 How Abortion Policy is Created in the Margins

Why is reconsidering these relationships key to understanding state abortion policy? I argue that the public is poorly informed about the types of abortion policies considered in state legislatures. As a result, the collective public's opinion on abortion policy is nebulous, granting significant discretion to policymakers. So long as policymakers do not propose policy perceived as too extreme by the public, legislators can pursue a variety of policies. Developing an understanding of how state policy makers (legislators, executives and bureaucrats) and interest groups strategically navigate policy making under the public's watch helps elucidate the state abortion policy environment.

Political scientists still think of abortion as a classic "easy" morality issue. As an easy issue, even people with low political sophistication can form opinions and understand policy. Yet, abortion policies adopted today are hardly easy. Policies are

often technical in nature, framed as regulation instead of morality, and the intended consequences of abortion legislation are not always clear to the mass public. For example, recently adopted Mississippi House Bill 1390[12] requires that all physicians who perform abortions have admitting privileges at a local hospital.[13] While the law is ostensibly about regulating the physicians, state Republicans were candid about celebrating the real effect of the policy after its passage - ending the availability of abortion in Mississippi.[14] When policies are technical or their real effects unclear - the pubic is less able to constrain policymakers.

How does public opinion constrain policymaking? V.O. Key (1961) conceived of public opinion as "a system of dikes which channel public action or which fix a range of discretion within which government may act or within which debate at official levels may proceed" (552). This opinion dike is the boundaries of possible policy adoption. When a policy is easily understood and salient, and constituent preferences are consensual on an issue, the opinion dike is narrow and the range of available policy alternatives is small. However, when policies are technical, difficult to understand, or not salient to the public, there is a permissive policy environment with wide opinion dikes, in which policy makers have greater discretion to adopt policies that reflect their own preferences (or those of organized interests) and not those of the public.

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[12]A U.S. District Judge issued a temporary restraining order the day the new law was scheduled to take effect.

[13]Because hospitals have the right to refuse admitting privileges to physicians and the Catholic-affiliated hospitals in Jackson (where the only remaining abortion clinic is located) refused, leaving the clinic unable to comply with the law when it took effect on July 1, 2013. Most hospitals require that doctors with privileges admit a certain number of patients a month; this is problematic given that abortion is nearly always an outpatient procedure.

[14]For example, Republican state Representative Bubba Carpenter said, "We have literally stopped abortion in the state of Mississippi" and Governor Bryant said "Today you see the first step in a movement, I believe, to do what we campaigned on - to say we're going to try to end abortion in Mississippi."

Legislators are aware that abortion is a controversial issue for voters. Because public opinion generally supports the legality of abortion, it may be against the electoral interests of most legislators to be active on the issue of abortion policy. As a result, most legislators will not introduce abortion. However, some legislators may benefit from taking an extreme position on abortion. For example, legislators may use abortion issues as a form of position taking when facing a competitive reelection. Legislators that are particularly active on the issue of abortion may also benefit from more campaign contributions from interest groups.

In cases where abortion policy is very contentious, legislators will struggle to pass restrictive bills through usual the legislative channels. Bills may be unsuccessful because too few legislators will publicly support the bill or because of gatekeeping actions from committees or chamber leaders block the bill. In these cases, policymakers may strategically pursue legislation in the bureaucracy. By granting the bureaucracy discretion to adopt and implement regulation, the bureaucracy has leeway to make "invisible" policy that is generally under the radar of the public's watch. Furthermore, because bureaucrats are appointed and not elected, they do not face the same electoral constraints as members of the legislature. As a result, they may be more willing to take an extreme abortion position.

2.4 Looking at Policymaking Across Time, Policy, and Policymaking Stages

Studying a single policy at discrete moments in time carries an implicit assumption that the determinants of policy are constant across anti- and pro- abortion rights policies, within these categories, and across time. The contradictory results of previous scholarship on abortion policy are partially explained by the selection of different policies for study. For example, Berkman and O'Connor (1993) find that women legislators are significant predictors of parental notification laws but not bans

on public funding of abortions.

Even slight variations in the substance of policy can change the influence of "moral" political forces (Pierce and Miller 1999). The framing of public policy is always important, but the framing of morality policies is crucial. Activists and lobbyists can transform an issue of morality politics by reframing the issue as a redistributive one, i.e. "demoralizing" it such that it no longer has the characteristics of morality policy (Mooney and Lee 2001).[15]

Certain abortion policies may be more easily defined outside of the morality framework, such as public funding of abortions (see Meier and McFarlane 1993) and Targeted Restrictions of Abortion Providers (TRAP) policies, which place regulations on the licensing or architecture of abortion clinics that are not placed on other comparable health facilities (Medoff and Dennis 2011). Some types of restrictive abortion policies are by specific factors that are generally insignificant in predicting the adoption of abortion policy and vice versa. Furthermore, the few studies that do look at both liberal and conservative abortion policies combine the policies into a net scale (such as Cambocreco and Barnello 2008), such that we have a weak understanding of how the determinants of anti- abortion policies may differ from pro-abortion rights policy. For this reason, it is imperative that a comprehensive analysis of abortion policy includes many policies (both anti- and pro-abortion rights) and studies the policies over an extended time period.

It is also important to look at what shapes policy across different stages of the policy process, as each phase of the policy process invokes different political, social and economic considerations (Smith and Larimer 2009). Earlier stages of the

[15]More recently, some scholars are moving away from classifying policies as being "moral" in nature and instead looking at the ways in which individuals use moralized views or rhetoric in the formation of their attitudes on given policies (see Graham, Haidt, Nosek 2009; Weber and Federico 2013; Clifford and Jerit 2013; and Ryan 2014).

policy process can also change the context around latter stages. The introduction of a bill may lead to a counter mobilization effort by changing the nature of debate on the topic (Schattschneider 1975). The incentives for legislative activity across the different stages of policymaking may also differ; legislators may use agenda setting as signal to their constituents even when bill passage is unlikely. Interest groups and social movements may exert more influence over earlier stages of the policy process (King, Cornwall, Dahlin 2005). Various studies that evaluate the policymaking across different stages find the determinants of policy at each stage to be distinct (Karch 2007; King, Cornwall, Dahlin 2005; Whiaker, Herian, Larimer and Lang 2012).

This dissertation seeks to define, explain and test the roles of these actors in modern abortion policy. I argue that role of these actors are different across stages of the policy process, and have changed over time. The agenda setting stage is less salient than policy adoption, and as such, legislators have more discretion to introduce policies that fit their own preferences. As a result, individual legislator characteristics and interest groups have the greatest effect on introducing policy. Policy makers use the issue of abortion when position taking, so abortion policy introductions are more likely in competitive electoral districts and during election years. In the policy adoption stage, the legislative chamber environment is more important than the individuals in the legislature. For example, the presence of a large contingent of Democratic women should have no effect on the probability of a legislator introducing a conservative abortion bill but a large contingent of Democratic women makes the adoption of that bill less likely. Because policy adoption is the most visible stage of policymaking, public opinion and constituent preferences are more important. Finally, policy implementation is the least visible stage. Legislators know that the pursuit of abortion policies can be electorally risky, and thus strategically grant more discretion to the bureaucracy under certain conditions. State executives also use the bureaucracy to adopt regulations that would be unsuccessful in the state

legislature.

CHAPTER 3
AGENDA SETTING

Established in 1971, the Americans United for Life (AUL) is a 501(c)(3) nonprofit organization that prides itself on being the country's first national group opposed to legal abortion. According to their website, they provide "state lawmakers, state attorneys general, public policy groups, lobbyists, the media, and others with proven legal strategies and tools that will, step-by-step and state-by-state, lead to a more pro-life America and help set the stage of the state-by-state battle that will follow Roe's ultimate reversal" (AUL website)[1]. AUL claims that it is partially responsible for the adoption of 28 restrictive abortion policies in 2011, 19 more in 2012, and 16 in 2013 - about one-third of all pro-life laws enacted in that time period (AUL Annual State Legislative Reports). The National Right to Life Committee (NRLC) claims credit for legislation that imposes a 20-week gestational ban in 10 states in 2013 and a similar bill in the U.S. House of Representatives that is based off their own model bill (NRLC Press Release, 7/18/2013).

The influence of AUL, NRLC and other similar groups on the legislative process is notable. The AUL legal team has been at work in 39 states and as of 2013 had responded to more than 2,500 requests for model legislation (AUL Press Release 2/7/2013). The non-partisan Sunlight Foundation found significant text overlap between AUL's model legislation and bills in 13 states, as well as a measure that had already been enacted in Texas. These textual similarities include relatively obscure phrasing that would not have occurred by change (Sibley 2012). The contribution of these groups and their model legislation is also acknowledged by legislators, including the Missouri House, which adopted a resolution in 2012 honoring AUL and its

[1]http://www.aul.org/issue/abortion/

president for "producing constitutionally-sound model legislation and expert advice on bills pending before this body" (Lee 2014).

Extensive previous research on agenda setting, both on general policy areas and women's issues more specifically, have focused on how a legislator's constituency, party affiliation and identity shape their propensity to introduce bills. However, very little research has explored the way that interest groups influence patterns of policy introduction beyond these commonly studied factors. This chapter evaluates how interest groups shape the abortion agenda in the states. Which legislators are most likely to be influenced by abortion interest group spending?

3.1 The Motivations for Introducing Bills

Legislators have only limited time and resources. Thus, how they choose to spend their valuable time reveals information about their "intensities," which are a product of personal and political incentives (Hall 1996). Sponsoring a bill takes significant time and resources, so bill sponsorship is a good indicator of a legislator's policy priorities. Scholars have used bill introductions to assess policy priorities at both the national level (Adler and Wilkerson 2005, Swers 2002) and state level (e.g. Baumgartner, Gray and Lowery 2009, Osborn 2012, Pacheco and Boushey 2014).

Abortion policies are often introduced in legislatures as a form of position taking, to motivate and energize a base of supporters. This is significant given that "politicians often get rewarded for taking positions rather than achieving effects" (Mayhew 2001, 51). Highton and Rocca (2005) show that members of Congress position-take on the issue of abortion in a variety of ways, and that roll-call position taking is more constrained by partisan factors than non-roll-call position taking. Thus, the factors that shape agenda setting differ in significant ways from those that predict policy adoption.

Legislators provide substantive representation by introducing and voting for

policies that are supported by their constituents because they almost always want to win reelection (Mayhew 1974, Page and Shapiro 1983, Downs 1957). For this reason, public opinion is highly correlated with policy outcomes, leading scholars to conclude that state politics are responsive to constituent preferences (Erickson, Wright and McIver 1993, Burnstein 2003).

The heterogeneity of the constituency may also influence legislators' position taking. However, this relationship is unclear. Some scholars find support for the theory that a heterogeneous constituency leads to more electoral competition, and thus more ideological, partisan, and extreme positions (Gulati 2004). Others find empirical support for Shepsle's (1972) theory that legislators in competitive districts will be less likely to take clear positions on policies to appeal to a broader electoral constituency (Jones 2003).

Parties work to set the legislative agenda by exerting influence over committee assignments and procedures, which determines what bills make it far enough through the legislative process to reach the floor for debate (Cox and McCubbins 2004). However, this power does not affect who is permitted to introduce bills. Instead, partisanship shapes bill introductions through the party affiliation of individual legislators. Agenda setting may be especially important for the minority party, as their policy preferences may be less likely to be enacted. As a result, introducing bills is a crucial way for minority party members to claim credit.

Legislators also have distinctive agenda setting patterns based on their group identification. While a significant number of women may be necessary to change the likelihood of abortion policy adoption, the nature of the agenda setting process means that women have more opportunities to represent women's policy interests earlier in the legislative process. There is substantial evidence that women influence the legislative agenda by sponsoring and cosponsoring bills that reflect their gender-role related issues, such as women's rights, welfare, health, education and children (i.e.,

Diamond 1977, Saint-Germain 1989, Dodson and Carroll 1991,Thomas and Welch 1991, Thomas 1994, Tamers 1995, Bratton and Haynie 1999, Carroll 2001, Bratton 2002, Bratton 2005,Wolbrecht 2002, Swers 2002, Dodson 2006). However, some studies find that women are not more active on women's issues and which specific issues are measured may partially explain this inconsistency (Dodson and Carroll 1991, Reingold 2000). In general, when there are more women from diverse perspectives, there is a greater focus on feminist women's issues in the chamber (Bratton 2002; Bratton 2005; Thomas, Rickert, and Cannon 2006).

Gender differences among legislators are moderated by the partisan context of the legislature. For example, partisan control of the legislature may influence how willing women are to introduce women's issue bills. For example, Republican women may be more likely to introduce social welfare policies and less likely to introduce controversial women's policies (such as those that regulate abortion) when their own party is in control (Swers 2002, Bratton and Barnello 2002, Dodson 2005). Partisan affiliation also mediates partisan women's legislative activity by shaping their likelihood of sponsoring policy and the content of the policy proposals (Tatalovich and Shier 1993, Bratton 2002, Bratton and Barnello 2002, Bratton 2005, Osborn 2012).

An understudied motivation for policy activity is the presence of a significant constituency of activists and interest groups with strong abortion policy preferences. There are active groups on both sides of the abortion debate, including anti-abortion groups like the National Right to Life Committee (NRLC), Americans United for Life (AUL) and the Susan B. Anthony List and pro-abortion rights groups like NARAL, Planned Parenthood, and Emily's List and the state-level affiliates of these groups. These groups assist in the legislative process by acting as legislative subsidies or congressional staff (Bauer, Pool and Dexter 1965, Hall and Deardorf 2006). They help frame issues, raise the salience of the debate, and create model legislation.

Far less research has evaluated the role of interest groups on agenda setting

(see Hojnacki, Kimball, Baumgartner, Berry and Leech 2012 for a review), so significant questions about the effect of interest groups at this stage remain. Some political scientists and sociologists argue that interest groups and social movements have the most influence at early stages of the policymaking process (Witcko 2006, King, Cornwall, Dahlin 2005,Soule and King 2006). Because each stage of the legislative process has increasingly stringent rules and more consequential outcomes, legislators respond to interest groups and social movements more in the agenda setting stage than voting (King, Cornwall, Dahlin 2005). However, other studies on the effect of interest groups on bill introductions finds no influence (Fellowes, Gray and Lowrey 2006).

3.2 Theory and Expectations

Legislators have several considerations when introducing abortion policy. The key to understanding why policy is introduced is to examine the various incentives faced by legislators.[2] First, legislators may introduce policy that is favored by most people in their district in order to secure their reelection and provide substantive representation. Legislators are more likely to introduce abortion policy that reflects the preferences of their constituents. There are no available measures of district-level opinion on abortion. However, opinion on abortion is correlated with conservative ideology. The constituency may also matter in terms of the degree of competitive the district elections. Legislators who won their seat with a small margin may be more

[2]Legislators also introduce policy that aligns with their own policy preferences. Some legislators voluntarily provide the public with their opinion on important issues, such as through the Political Courage Test administered by the non-partisan Project Vote Smart. However, participation rates on this survey have declined significantly over time at the behest of party leaders and political consultants (Lynch 2014). On this test, and others like it, partisan identification and gender are highly predictive of abortion opinion. Thus in the absence of an explicit policy statement on abortion, legislator's party affiliation and gender are a good representation of a legislator's policy preference.

active at taking partisan positions.[3]

> *Constituent Ideology: A greater percent of ideologically conservative constituents in their district will increase the probability that a legislator will introduce anti-abortion rights policy and decrease the probability of pro-abortion rights policy.*
>
> *Electoral Competition: Legislators representing competitive electoral districts will be more likely to introduce both anti- and pro-abortion rights policy.*

Legislators introduce policy that supports their party's agenda. Since the mid 1980s, the political parties have had distinct platforms regarding abortion, with the Republican party supporting a broad array of restrictions on abortion and the Democratic party supporting legal abortion with few restrictions. Legislators will be more likely to introduce abortion policy that aligns with their party platform.

> *Party Affiliation: Republicans will be more likely to introduce anti-abortion rights policy and Democrats will be more likely to introduce pro-abortion rights policy.*

Women legislators tend to have more liberal policy preferences regarding women's issues generally. When it comes to the issue of abortion, women are more likely to oppose conservative abortion policy and support liberal abortion policy. However, when it comes to the issue of abortion, Republican women face cross-pressures based on their gender and party. In order to avoid the ire of their political party, Republican women are less active on the issue of abortion. Democratic women, whose party and gender both increase their likelihood of having liberal abortion preferences, will be very active in introducing liberal abortion policy.

> *Legislator's Gender: Democratic women will more likely to introduce pro-abortion rights policy and less likely to introduce anti-abortion rights policy, relative to their male counterparts and Republicans. Republican women will be less active on legislating abortion.*

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[3]However, as mentioned above, there is conflicting scholarship on the relationship between electoral competition and agenda setting.

Abortion organized groups may influence the legislative agenda beyond these common explanations of legislator sponsorship activity. Legislators introduce policy when an electorally useful constituency, such as wealthy donors or interest groups that contribute to the legislator?s reelection, supports it. Legislators who have received a campaign contribution from a group that advocates for or against legal abortion may provide more develop a rapport with and provide access to abortion interest groups. As a result, they may dedicate more of their time to the issue of abortion, including introducing abortion-related bills. However, not all legislators are equally likely to be swayed by the influence of abortion groups. Therefore, the effect of interest groups may be limited to legislators who are already likely to introduce abortion policy based on their gender and party.

> *Interest Groups: Legislators who have received a contribution from an anti-abortion rights group will be more likely to introduce anti-abortion rights policy. Legislators who have received a contribution from a pro-abortion rights group will be more likely to introduce pro-abortion rights policy. The effect may be larger for Republicans and men when relating to anti-abortion rights policy and Democrats and women for pro-abortion rights policy.*

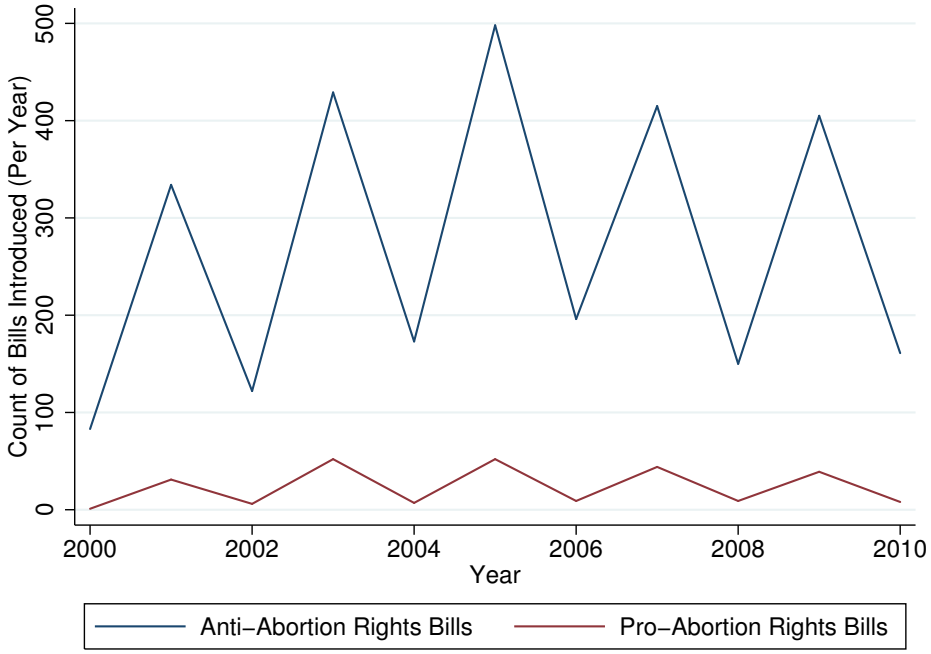
3.3 Empirical Approach

3.3.1 Dependent Variable

In order to analyze which legislators introduce abortion bills and the timing of these introductions, I use an original dataset of abortion-related bill introductions. The dataset is comprised of all bills with the word “abortion” in the bill summary, collected from Lexis Nexis State Capitol. The data includes both upper and lower chambers, and spans from 2000 to 2010. The number of anti-abortion rights bills introduced in a two-year period has slightly increased over time, with far more bill introductions in odd-numbered years (see Figure 3.1). Representatives use the issue of abortion to frame the tone of new legislative sessions; so abortion-related bill

introductions may be more likely in odd-numbered years, when most states start new sessions. Pro-abortion rights bills are far less common relative to their conservative counter-parts, with the same pattern of more bills introduced in odd-numbered years.

Figure 3.1: Count of Anti- and Pro-Abortion Rights Bill Introductions Per Year



The data includes a wide range of bills that regulate abortion in some way. I coded the substantive context of the bills based on the bill synopsis in order to verify that the bill primarily regulated abortion. I allowed each of the bills to have up to two primary substantive codes. A full list of the substantive bill types (primary code only) and their frequency can be seen in Table 3.1. Certain bills are far more common. For example bills that regulate access for minors or mandate specific informed consent procedures constitute a third of all restrictive abortion bill introductions.

The frequency of specific bill types over time also varies (see Figure 3.2). For

Table 3.1: Abortion Bill Substantive Codes

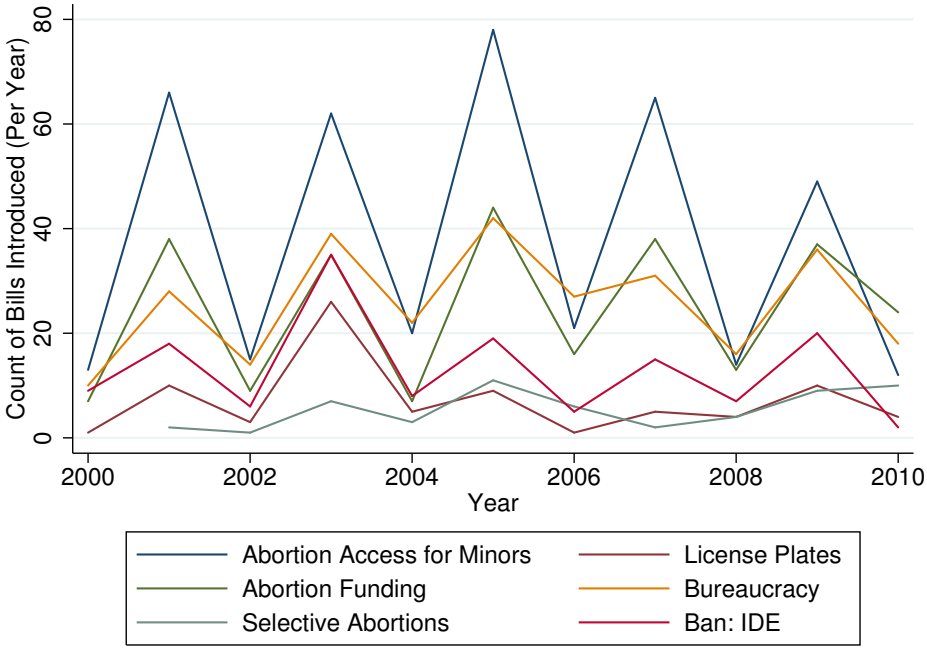
Substantive Topic	Anti-Abortion Rights	Pro-Abortion Rights
Abortion Access for Minors	395	22
Informed Consent	477	16
Waiting Periods	18	1
Ban on IDE Procedure ("Partial Birth")	141	4
Fetal Tissue	79	6
Abortion Funding	255	18
Insurance	62	26
Abortion Facilities	112	1
Surgical Abortion Legality	199	9
Medical Abortion Legality	33	2
Contraception	3	23
Emergency Contraception	5	6
Bureaucracy	269	16
Clinic Access	4	24
License Plates	80	1
Personhood	66	2
Symbolic Gestures	17	3
Race/Gender Selective Abortions	54	1
Conscience Exemptions for Practitioners	108	0
Schools and Sex Ed	21	18
Admitting Privileges	17	0
Other	166	11
Total	**2693**	**256**

instance, bans on intact dilation and extraction procedures (commonly known as "Partial Birth Abortions") are most common in 2003, the same year the procedure was the focus of a law in Congress. Bills that allow for the sale of "pro-life" license plates to fund Crisis Pregnancy Centers also peaks in 2003, and becomes less common over time as most states enact this bill. Bills that prohibit abortion based on the fetus' race, gender, and perceived sexual orientation have come slightly more common in recent years. Interestingly, bills that impose additional bureaucratic requirements are less affected by the odd-numbered year pattern discussed above.

3.3.2 Independent Variables

Ideally, an analysis of the effect of constituent preferences on abortion bill introductions would include a measure of abortion opinion that matched the unit of analysis. In this chapter, I focus on the relationship between electoral districts and representatives. There are no district-level measures of abortion opinion. However,

Figure 3.2: Selected Abortion Bill Types Per Year



abortion opinion is correlated with ideology and partisanship. This is especially true after the political parties became more polarized on the issue of abortion in the 1980s (Adams 1997). To measure constituent ideology, I include a measure of the percent of the electoral district that voted for George W. Bush or Al Gore in the 2000 presidential election created by Wright, Osborn, and Winburn (2004). Specifically, I use a measure of the percent of the district that *voted for Bush* in the analyses of conservative abortion bills and *voted for Gore* in the analyses of liberal abortion bills. This measure was created by disaggregating election results to the precinct level, and aggregating the results up to the state legislative district. This is a valid measure of ideology and is highly correlated with an updated version of the CBS/*New York Times* measure of state ideology, though it does not distinguish between economic and moral conservatism.

Using data from the National Institute on Money in State Politics (NIMSP), I

evaluate the effect of abortion-focused interest groups on bill introductions by looking at the state abortion interest group environment and contributions to individual candidates. The NIMSP has the most comprehensive information on state-level interest group activity. Their data is compiled from reports issued from the states, however, the states vary significantly in what interest group data they provide and when it is available.[4] Using this data, I created two indicator variables for *candidates who have received interest group contributions from anti- and pro- abortion rights groups* in the past.[5] I control for the state abortion interest group environment with ordinal variables for the *amount of money received in that state from anti- and pro-abortion rights groups.* In order to maintain consistency in the way the interest group variables are coded, the variables are based off all contributions to the state in the past.

I estimate the effects of *partisan affiliation* and *legislator's gender* through the use of a set of indicator variables for Republican men, Republican women, Democratic men, and Democratic women. In the unified analyses, I use Democratic women as the omitted category as they have the most liberal abortion attitudes relative to the other groups. I also present analyses using subsamples of the data based on these variables. The party identification data comes from Klarner et al (2013). I coded legislator gender based on the legislator's first name. When the first name was unavailable or a gender-ambiguous name, I used internet research to identify the legislator's gender. I account for which party controls the legislative chambers with an indicator variable for *unified Republican control of the legislature* for the anti-abortion rights analysis

[4]State interest group data is missing for many states prior to 2000, so this analysis is limited to 2000 and later.

[5]I chose to model interest group influence in this way for several reasons. Theoretically, the effect of interest group contributions may not be confined to a year. A representative that has received money in the past may remain sympathetic to that cause or hope for future contributions. Empirically, most contributions occur in election years, before the beginning of the next legislative session. As a result, contributions are most likely in even-numbered years and most introductions occur in odd-numbered years.

and *unified Democratic control of the legislature* for the pro-abortion rights analysis (Klarner 2003).[6]

I hypothesized that legislators may be more likely to use the platform of abortion policy credit-claiming when they represent an *electorally competitive district*. I use an indicator variable for when the legislator's most recent electoral win was with less than 55% of the vote (Klarner et al 2013). Agenda setting may be more likely at the *beginning of the legislative session*, so I include an indicator variable for even-numbered years, when most states start new legislative sessions. Finally, abortion related bill introductions have increased over a time, so I use an ordinal variable for the *years* in the dataset.

3.3.3 Modeling Strategy

Because the bill introduction data are in event count format, I use a negative binomial regression.[7] I use robust clustered standard errors to account for the interdependence of legislator's behavior, as their likelihood to introduce bills is correlated over time. Abortion related bill introductions are very rare; however, models run using rare events logit and a dichotomous dependent variable find similar results.

I first estimate separate models for anti- and pro-abortion rights bill introductions. These models show the average predictors of bill introductions among all legislators. Next, I split the analysis into four legislator types - Republican men, Republican women, Democratic men, and Democratic women - to show how the predictors of agenda setting are different for these groups. I ran additional models

[6]The inferences from the models do not change when I use separate indicator variables for the upper and lower chambers.

[7]Poisson distributions are also appropriate for event count data, however, in a poisson distribution the mean and variance are the same. There is evidence of overdispersion in this data. Among the anti-abortion rights bills, the mean is .104 with a variance of .285. Among the pro-abortion rights bills, the mean is .007 with a variance of .015.

to show how agenda setting behavior varies across upper and lower chambers; however, the differences were minimal. Thus, I briefly mention the differences and refer interested readers to the appendix.

Among the anti-abortion rights bill introductions, there was an unusually high number of introductions from Democratic women in three states: Massachusetts, New Hampshire, and West Virginia. In these three states, the size of the Democratic delegation is very large, and there is a significant number of moderate or conservative Democrats. Democratic women in these states introduce a surprisingly high number of restrictive abortion policies. Democratic women in these three states account for 79.79% of anti-abortion rights bills introduced by women.[8] Because the behavior of Democratic women in these three states are so significantly different from trends in the rest of the country, I show models with and without these states when analyzing the anti-abortion rights bills. There was no similarly anomalous trend when looking at pro-abortion rights bills or other legislators in those states.

3.4 Results

I find evidence for all three of the motivating explanations for agenda setting behavior: constituent ideology, interest group activity and the legislator's gender and partisan identification (see Table 3.2). Model 1 show the full dataset of anti-abortion rights bill introductions and Model 2 show the same model but without the 3 anomalous states mentioned in the previous section. I focus my discussion on Model 2, given that the inclusion of the three states changes the effect of several theoretically significant variables. Model fit statistics support this decision, as they indicate that

[8]Democratic women in Massachusetts introduced 17.97%, in New Hampshire introduced 48.05% and West Virginia introduced 13.67% of anti-abortion rights bills introduced by women.

Model 2 is a better fitting model.[9] Model 3 shows a symmetrical set of predictors for pro-abortion rights bill introductions. For instance, the percent of the district that voted for Bush in 2000 in the anti-abortion rights models is the percent of the district that voted for Gore in the pro-abortion rights models.

The combination of legislators' gender and party strongly predict both types of abortion-related bill introductions. Republican men and women are more likely to introduce restrictive policy than their Democratic counterparts (see Model 2). There is no significant difference between Democratic men and women, indicating that both are similarly unlikely to introduce these bills.[10] Republican men and women are less likely to introduce pro-abortion rights bills. However, Democratic men and women behave differently regarding these policies - Democratic men are less likely than their female counterparts to introduce these bills.

There is a less clear connection between the public's policy preferences and their legislators' bill activity across the bill types. Constituent ideology appears to shape the likelihood that a legislator introduces certain abortion bills. Legislators are not more likely to introduce conservative abortion policy when their electorate is more conservative (as measured by the percent of the district that voted for Bush).[11] Liberal abortion bill introductions are more likely in districts where a greater percent of the district voted for Gore.

There is a correlation between interest group contributions to individual candidates and bill introductions. Legislators are more likely to introduce conservative

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[9]Table A.2 in the appendix shows the regression results for the three states alone.

[10]In Model 1, which includes the 3 anomalous states, Democratic men are actually less likely than Democratic women to introduce anti-abortion rights bills. This is because Democratic women in the three states are usually active on this issue.

[11]In Model 1, this variable is significant in the unexpected direction. It indicates that when the three anomalous states are included, conservative abortion-related bill introductions are more likely in liberal districts.

Table 3.2: Count of Abortion Rights Bills

Count of Abortion Bills	M1 Anti - 50 States	M2 Anti - 47 States	M3 Pro
Republican Man	0.369***	1.166***	-1.629***
	(0.082)	(0.179)	(0.248)
Republican Woman	0.467***	1.320***	-1.438***
	(0.103)	(0.191)	(0.323)
Democratic Man	-0.180**	0.097	-0.750***
	(0.084)	(0.191)	(0.232)
Percent Bush Vote in District	-0.005**	0.005	
	(0.002)	(0.003)	
Percent Gore Vote in District			0.022***
			(0.005)
Anti-Abortion IG Contrib. to Rep.	0.589***	0.852***	
	(0.115)	(0.142)	
Pro-Abortion IG Contrib. to Rep.			0.902***
			(0.245)
Anti-Abortion IG Contrib. in State	-1.383***	-1.340***	
	(0.092)	(0.126)	
Pro-Abortion IG Contrib. in State			-0.478***
			(0.122)
Rep. Control of Legislature	-0.401***	-0.437***	
	(0.057)	(0.088)	
Dem. Control of Legislature			1.140***
			(0.159)
Lower Chamber	0.192**	-0.317***	-0.170
	(0.088)	(0.093)	(0.175)
Won Less than 55%	1.500***	0.168*	1.569***
	(0.064)	(0.094)	(0.191)
Time Since 2000	-0.006	-0.000	0.038*
	(0.007)	(0.011)	(0.022)
Even Numbered Year	-1.324***	-0.655***	-1.136***
	(0.091)	(0.117)	(0.189)
constant	-2.243***	-3.646***	-6.438***
	(0.142)	(0.229)	(0.403)
lnalpha			
constant	2.133***	2.565***	4.083***
	(0.050)	(0.110)	(0.129)
N	76109	67726	76109
chi2	1510.34	723.61	471.38
aic	38474.39	17452.25	4040.66
bic	38594.51	17570.86	4160.78

Note: two tailed-tests, * p<0.01, ** p<0.05, *** p<0.01.

abortion bills when they have received a contribution from a group that opposes abortion and more likely to introduce liberal abortion bills when they have received a contribution from a pro-abortion rights group.[12] This is not necessarily a causal relationship, as interest groups likely contribute to legislators sympathetic to their respective causes. Nevertheless, there is a strong relationship. Interestingly, the amount of interest group contributions in the state is negatively related to bill introductions. This indicates that it is not the more broad state abortion interest-group context that is important; it is the connection between the interest groups and individual legislators.

Bill introductions are also related to which political party controls the legislative chambers.[13] I find that anti-abortion rights bill introductions are *less* likely when Republicans have unified control of the legislature. Legislators introduce more conservative abortion bills when the Democrats control the legislative process. This may be because bill introductions are an especially important form of agenda setting for the minority party. Thus, when Democrats control the legislature, Republicans resort to more abortion bill introductions. The same relationship is not true for pro-abortion rights bills. A greater number of these bills are also more likely when Democrats are in charge.

The state electoral and temporal contexts are also significant predictors of abortion bill introductions. Both types of bill introductions are more common when the legislators represent electorally competitive elections. When incumbency is at

[12]This relationship is not significant when interest group contributions are coded by year. It appears that a contribution in the past is a better predictor of abortion policy introduction than a contribution in the same or preceding year. This is likely because most contributions occur in even-numbered election years and most bills are introduced in odd-numbered years.

[13]In alternative modes not shown, I also model partisan control with separate indicators for control of the upper and lower chambers. The inferences from these models are the same.

stake, legislators become more active on legislating abortion. Bill introductions for both types of bills are less likely in even numbered years, indicating that abortion bills are introduced at the beginning of the legislative session, which tend to be in odd-numbered years. The indicator for years since 2000 was surprisingly not significant in the model for anti-abortion rights bills, despite the actual incidence of bill introductions increasing over time for both types of bills.

3.4.1 The Differences Across Gender and Party

The predictors of abortion-related bill introductions vary across gender and party types for both kinds of legislation. Tables 3.3 and 3.4 replicate Models 2 and 3 from Table 3.2 with models based on split samples. In general, there are few significant differences between Republican men and women for either type of policy. The discrepancies that do exist may be attributed to the size of errors for the much smaller sample of Republican women. There are more significant differences between Democratic men and women for both types of policy.

Republicans are more likely to introduce anti-abortion rights bills when the percent of their district that voted for Bush is smaller. This surprising finding indicates that Republicans are more likely to introduce abortion bills when they represent a more moderate or liberal district. There is no significant relationship between district ideology and Democrats' bill introduction activity.

Interest group contributions from anti-abortion rights groups to representatives and Republican control of the legislature are significant and positive for both groups of men, but not women. Men are more likely to introduce bills when Democrats control the legislature (partially supporting the contention that agenda setting is more important for the minority party) and when they receive money from conservative abortion interest groups.

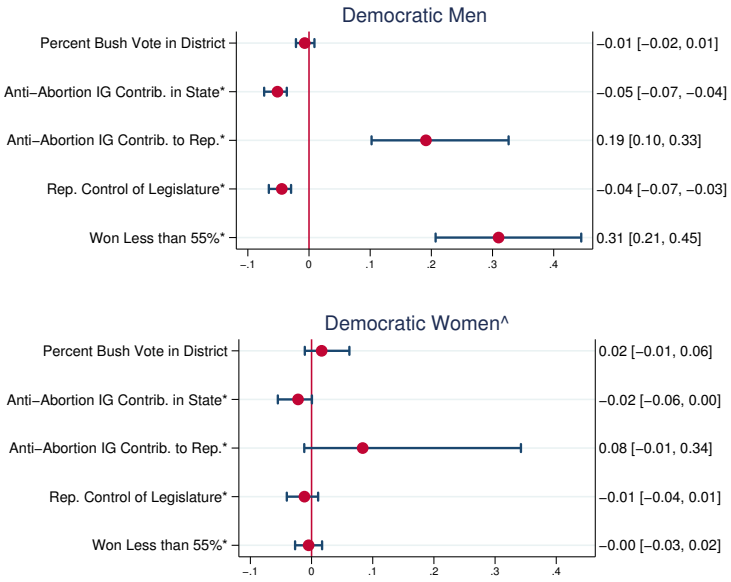
The competitiveness of the legislators' electoral district is strongly predictive of

Table 3.3: Count of Anti-Abortion Rights Bills, by Gender and Party

	M4 Rep.Man	M5 Rep.Wom.	M6 Dem.Man	M7 Dem.Wom.
Count of Anti-Abortion Bills				
Percent Bush Vote in District	-0.015***	-0.015**	-0.003	0.013
	(0.004)	(0.007)	(0.003)	(0.011)
Anti-Abortion IG Contrib. to Rep.	0.282*	0.283	1.279***	0.985
	(0.151)	(0.256)	(0.212)	(0.736)
Anti-Abortion IG Contrib. in State	-1.549***	-1.029***	-1.252***	-1.179*
	(0.155)	(0.256)	(0.106)	(0.614)
Rep. Control of Legislature	-0.346***	-0.080	-0.947***	-0.416
	(0.084)	(0.138)	(0.106)	(0.384)
Lower Chamber	0.060	-0.140	0.260	-0.141
	(0.117)	(0.220)	(0.180)	(0.349)
Won Less than 55%	1.283***	1.342***	1.661***	-0.181
	(0.100)	(0.156)	(0.109)	(0.303)
Time Since 2000	0.002	0.031	-0.015	0.014
	(0.011)	(0.019)	(0.013)	(0.038)
Even Numbered Year	-1.049***	-1.620***	-1.367***	-1.434***
	(0.151)	(0.218)	(0.107)	(0.309)
constant	-1.257***	-1.165***	-2.498***	-3.944***
	(0.246)	(0.421)	(0.209)	(0.633)
lnalpha				
constant	2.041***	1.637***	2.451***	3.390***
	(0.084)	(0.114)	(0.086)	(0.223)
N	30426	6488	28069	9193
chi2	510.69	204.96	874.63	49.10
aic	17354.21	4406.61	10947.52	1245.24
bic	17437.44	4474.38	11029.95	1316.50

Note: two tailed-tests, * p<0.01, ** p<0.05, *** p<0.01.

Figure 3.3: Democratic Men and Women, Anti-Abortion Rights Bills



First Differences represent a change from 1 SD below the mean to 1 SD above the mean.
Variables with a * are discrete, with the First Difference a change from 0 to 1.
^Massachusettes, New Hampshire and West Virginia are excluded.

their likelihood of abortion agenda setting. Democratic women are the only group that are not more likely to introduce this type of policy when hailing from a competitive district. In fact, few variables are significant predictors for Democratic women, likely because very few Democratic women introduce restrictive abortion policy outside of the 3 anomalous states of New Hampshire, Massachusetts and West Virginia. Figure 3.3 shows the first difference for selected variables for Democratic men and women. Compared to Democratic women, the substantive effect of anti-abortion rights interest group contributions and competitive elections for Democratic men is larger.

When looking at pro-abortion rights bills, the set of predictors for Republican men and women are quite similar (see Table 3.4). However, there are a few notable differences. Republican men are more likely to introduce these bills when Democrats control the legislative chamber, and Republican women are less likely to introduce bills in the lower chamber. The liberalness of the legislator's district is not significant

Table 3.4: Count of Pro-Abortion Rights Bills, by Gender and Party

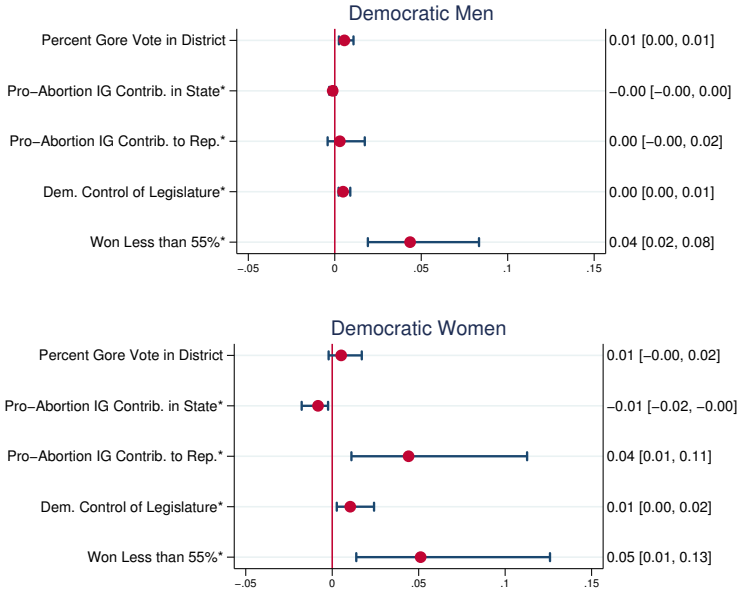
	M8 Rep.Man	M9 Rep.Wom.	M10 Dem.Man	M11 Dem.Wom.
Count of Pro-Abortion Bills				
Percent Gore Vote in District	0.020	0.006	0.037***	0.010
	(0.016)	(0.036)	(0.008)	(0.007)
Pro-Abortion IG Contrib. to Rep.	-18.747***	-13.100***	0.304	1.230***
	(0.291)	(0.409)	(0.553)	(0.315)
Pro-Abortion IG Contrib. in State	-0.671**	-0.467**	-0.243	-0.648***
	(0.312)	(0.227)	(0.184)	(0.221)
Dem. Control of Legislature	0.983***	0.550	1.657***	0.882***
	(0.291)	(0.573)	(0.299)	(0.276)
Lower Chamber	-0.345	-1.012**	-0.002	-0.208
	(0.371)	(0.509)	(0.288)	(0.320)
Won Less than 55%	0.956***	1.641***	2.112***	1.331***
	(0.290)	(0.579)	(0.311)	(0.308)
Time Since 2000	0.023	-0.023	0.042	0.043
	(0.050)	(0.086)	(0.035)	(0.035)
Even Numbered Year	-1.032**	-2.433***	-1.308***	-1.033***
	(0.429)	(0.889)	(0.237)	(0.363)
constant	-7.350***	-5.707***	-8.838***	-5.592***
	(0.751)	(1.545)	(0.689)	(0.522)
lnalpha				
constant	4.867***	3.345***	4.392***	3.578***
	(0.252)	(0.767)	(0.164)	(0.169)
N	30426	6488	28069	10674
chi2	5318.96	1444.77	238.39	202.39
aic	643.88	205.09	1609.65	1561.33
bic	727.11	272.87	1692.08	1634.09

Note: two tailed-tests, * p<0.01, ** p<0.05, *** p<0.01.

for either group and all Republicans are less likely to introduce pro-abortion rights bills when they are previous recipients of a liberal abortion interest group.

Once again, there are more differences between Democratic men and women. Figure 3.4 shows the substantive effects of key variables for Democratic men and women. Democratic men are more likely to introduce pro-abortion rights bills when their district is more liberal, but this is not a significant factor for women. This is likely because Democratic women tend to be elected from more liberal districts anyway. Interest group contributions from pro-abortion rights groups have no significance for men, but are significant and positive for Democratic women. This may be because most pro-abortion rights bills are introduced by Democratic women and an exceptionally high number of Democratic women received contributions from pro-abortion rights groups (22.95% compared to 6.42% for Democratic men; see appendix Table A.1 for the percent of each group receiving funds from each type of group).

Figure 3.4: Democratic Men and Women, Pro-Abortion Rights Bills



First Differences represent a change from 1 SD below the mean to 1 SD above the mean.
Variables with a * are discrete, with the First Difference a change from 0 to 1.

3.4.2 The Differences Across Upper and Lower Chambers

In general, the patterns that predict abortion-related bill introductions are similar across upper and lower chambers for both types of policies (see Table A.3 in the appendix). However, there are a few notable differences. Among anti-abortion rights bills, conservative constituents are significant and positive, Republican control of the government is negative and significant, and competitive districts are significant only for the lower chamber. Among pro-abortion rights bills, there are two notable differences. Competitive elections are only significant and positive for lower chambers. Additionally, there is no statistically significant difference in the likelihood of Republican women and Democratic women introducing liberal abortion bills.

3.5 Conclusion

Why do legislators introduce abortion-related bills in state legislatures when they are unlikely to pass and sponsoring a bill expends legislators' limited time and resources? The motivation for making abortion policy a legislative priority can stem from constituent preferences, from interest group support, or the legislators' gender and party identification. This chapter tests these competing motivations simultaneously, by looking at abortion bill sponsorship from 2000-2010.

I find some support for all three motivations for abortion policy sponsorship. More importantly, I find that when and how influential these factors are depends on the legislator's gender and party identification. The influence of constituent ideology is limited to Republicans when it comes to anti-abortion rights bills and Democratic men for pro-abortion rights bills. I find that an increased presence of abortion-specific interest groups in the state is negatively related to abortion bill introductions. However, anti-abortion interest group contributions are a significant predictor of anti-abortion bill introductions among men. I also find that pro-abortion interest group contributions are significant and negatively associated with Republicans, but signif-

icant and positively associated with Democratic women. Finally, I see that the legislative, temporal and electoral context matters. Legislators introduce more abortion policy when the Democrats control the legislature, when they represent competitive electoral districts, and at the beginning of most legislative sessions.

This chapter makes several contributions to the literature. First, I use a new dataset of all abortion-related bills in state legislatures from 2000-2010. Previous research on abortion bill introductions has focused on Congress (such as McTague and Pearson-Markowitz 2014, who look at the U.S. Senate), on specific years in a subset of states (such as Bratton and Haynie 1999, who look at bill introductions in the lower chambers of six states in 1969, 1979, and 1989), or on single-state studies over time. Second, very few studies have looked at the influence of interest groups in the early stages of the policy process. This chapter finds a strong relationship between interest group contributions and legislator's likelihood of introducing abortion-related bills. Additionally, using data from all state chambers in a ten-year period allows me the opportunity to look at how sponsorship patterns vary across different groups of legislators and over time. I find that women and partisans are motivated to introduce abortion policy for different reasons.

Although this chapter reveals some interesting patterns about which legislators introduce abortion bills in state legislatures, there are several limitations to this research design. By looking at a count of the total number of abortion bills introduced by each legislator in each year, I am ignoring the variation that likely exists across the different types of abortion bills. For example, bills that propose additional reporting requirements for abortion clinics may be introduced by different legislators than bills that propose monetary allocations for crisis pregnancy centers or longer waiting periods. In their book on abortion policy in Congress, Ainsworth and Hall (2011) find differences in which legislators introduce incremental and non-incremental policy. That nuance is also lost in this approach. Finally, we know that legislators are

influenced by interest groups through means beyond campaign contributions (such as the model legislation discussed a the beginning of the chapter). This influence of interest groups is not easily captured in the sort of data analyzed here.

CHAPTER 4
POLICY ADOPTION

When studying state abortion policy, scholars typically focus on a specific policy in a single time period. Political scientists with different research agendas have focused on different causal narratives, generally using one of two common sets of explanatory variables. There is evidence that abortion policy is well explained by the morality politics paradigm, which argues that the high salience and technical simplicity of policies that regulate morality engender high levels of citizen engagement (Mooney and Lee 1995; Meier and McFarlane 1993). As such, morality policy in particular is responsive to public opinion and religious forces (Cook, Jelen, and Wilcox 1992; Goggin and Wlezien 1993, Norrander and Wilcox 2001, Wetstein and Albritton 1995; Wilcox 1989; Cohen and Barilleaux 1993; Cambocreco and Barnello 2008). Alternatively, scholars also explain the adoption of abortion policy with politics - who runs the government. Abortion policies are shaped through representation, by the gender and partisanship of state legislators. States with more female Democratic legislators (Berkman and O'Connor 1993; Hansen 1993; Tatalovich and Sheier 1993; Wetstein 1996; Norrander and Wilcox 2001), Democratic control of the legislative chambers (Berkman and O'Connor 1993; O'Connor and Berkman 1995; Norrander and Wilcox 2001), and a "pro-choice" governor (Wetstein 1996) are less likely to have restrictive abortion policies.

There is no reason that the morality politics model and representation model cannot both contribute to the explanation of abortion policy adoption. In fact, it is through descriptive and partisan representation that the public's preferences are articulated into policy. Yet previous studies of the diffusion of abortion policy find conflicting results regarding the influence of morality or partisan politics that empha-

size one explanation of policy at the expense of the other.[1] For example, Mooney and Lee (1995) study pre-*Roe* abortion reform and find that public opinion and religiosity of constituents have a significant effect on state abortion policy reform. They determine that socioeconomic variables and state innovativeness did *not* predict abortion regulation and note that their conclusions are consistent with the extant literature on morality policy (622). Alternatively, Medoff and Dennis' (2011) study of Targeted Restrictions on Abortion Provider (TRAP) laws finds that religious constituents, public opinion, and ideology are insignificant predictors of abortion policy and conclude that "abortion is a redistributive issue and not a morality issue" (951). The contradictory results of previous scholarship on abortion policy can be at least partially explained by the selection of different policies for study.

The objectives of this chapter are to come up with a single model that tests extant explanations for abortion policy adoption and establish a set of determinants for the state abortion policy environment. I briefly review the two streams of literature that are most commonly used to explain abortion policy adoption: morality policy and political representation. I theorize about the predictors of abortion policy, including why the determinants of pro- and anti- abortion rights policy may vary. I then employ discrete pooled event history analysis on a set of 29 anti- abortion policies (those that restrict access to legal abortion) and a set of 8 pro-abortion rights policies (those that maintain or expand abortion access) from 1973-2013. This approach allows me to identify a set of predictors of state abortion policy (including a newly created dynamic measure of state abortion opinion) that is less susceptible to case selection

[1]Mooney and Lee's (1995) study of pre-*Roe* abortion reform policies and Patton's (2007) study of parental consent, mandatory counseling and delay policies, post-viability bans and spousal consent requirements emphasize morality policy variables and the constitutional context, but Medoff and Dennis's (2011) study of TRAP policies and Medoff, Dennis, and Stephens's (2011) study of parental consent laws emphasize the partisan and institutional predictors of policy.

bias than previous studies, and provides an opportunity to comprehensively explore the forces that shape abortion rights policy in these states.

I find that constituent values and partisan factors both explain anti-abortion rights policies, but that the effect of conservative attitudes about abortion is conditional on the strength of Republican control of the legislature. Pro-abortion rights policy is less clearly explained. Democratic women have no significant effect on pro-abortion rights policy, which is largely explained by religious constituents and Republican control of the legislature. Additionally, I explore the heterogeneity of these variables across anti-abortion rights policies. I find that while the morality policy variables have a homogeneous effect, there are differential effects for Democratic women and Democratic control of the state executive across policies. Politics have a stronger negative effect on some anti-abortion policies than others.

4.1 Two Common Explanations of Abortion Policy Adoption

There are two explanations for abortion policy commonly found in the existing literature. While these explanations are not inherently in competition, and in fact may be complimentary, scholars in pursuit of different research agendas have focused their studies on morality policy or on representation. Without a comprehensive study of abortion policy that includes variables for both theories simultaneously, we lack understanding of how these different elements work together to shape policy.

4.1.1 Morality Policy and Constituent Preferences

Morality policies are those in which at least one side of the debate frames the issue in terms of morality or sin, and the policies seek to validate one set of values at the expense of others (Haider-Markel and Meier 1996; Meier 2001). They tend to be technically simple and everyone can legitimately claim to be well informed; they are conflicts of "first principle" and highly salient to the public; and as a result, they

have a higher than normal level of citizen participation (Mooney 2001a; 7-8). Scholars have long argued that policy, and morality policy in particular, is responsive to public opinion (such as Goggin and Wlezien 1993; Norrander and Wilcox 2001; Wetstein and Albritton 1995), and that this responsiveness may be enhanced in states with the initiative process (Gerber 1996; Arceneaux 2002; Bowler and Donovan 2004). For example, Gerber (1996) finds that the probability of having a parental notification or consent law increased with supportive public opinion, and that the probability of having such a law is higher in initiative states compared to non-initiative states at each level of voter preference.

Legislators also face grassroots pressures from the strongly held beliefs of religious constituents opposed to abortion (Norrander and Wilcox 2001). Religious constituencies can have both a direct and indirect effect on policy. It is likely *indirect* in that individual opinion on abortion is highly correlated with religious orientations, with evangelical Protestants and Catholics more opposed to abortion than "mainline" protestants, Jewish or secular citizens (Jelen and Wilcox 2003). Abortion attitudes are very salient for some religious denominations, with religious citizens who attend services frequently even more likely to oppose legal abortion (Evans 2002). The effect of religious constituents is also *direct*, in that church attendees are often mobilized on politicized morality issues such as abortion through their churches (Verba, Schlozman and Brady 1995; Fabrizio 2001). In the previous abortion literature, religious populations have been used as a proxy for public attitudes on abortion (Strickland and Whicker 1992; Berkman and O'Connor 1993) and as a surrogate for interest groups support (Berkman and O'Connor 1993; Hansen 1993; Norrander and Wilcox 1999; Cohen and Barrileaux 1993; Norrander and Wilcox 2001, Meier and McFarlane 1993).

4.1.2 Descriptive and Partisan Representation

Demographic characteristics such as partisan identification, gender, religious identification and attendance, and other socio-cultural variables shape individual's opinions on abortion. These same attributes affect individual legislators' likelihood of supporting abortion legislation. The most significant of these attributes are gender, partisanship and religion.

As a result of the two major political parties' distinct platforms on the issue of abortion, the state political context influences state abortion policy. Political parties control the legislative process through party discipline (Aldrich and Rhode 2001); thus, partisan control of the legislative and executive branches has a significant effect on the policies adopted in the states. The polarization of the two parties is a contributing factor - when the Republican party is more conservative abortion policy adoption is even more likely (Ainsworth and Hall 2011).

As the percent of women in the state legislature increase, conservative abortion policy becomes less likely. This relationship is particularly strong when focusing on only Democratic women (Hansen 1993; Tatalovich and Sheier 1993; Medoff 2002; Norrander and Wilcox 2001). However, this relationship does not exist for all abortion policies. For example, Berkman and O'Connor (1993) find that once women achieve critical mass in the legislature, parental involvement laws become less likely but there is no effect for bans on the public funding of abortions for low-income women. Gender is even more significant than religion in predicting a pro-abortion rights Republican vote (Tatalovich and Sheier 1993).

4.1.3 Different Policies, Different Findings

The framing of public policy is always important, but the framing of morality policies is crucial. Activists and lobbyists can transform an issue of morality politics by reframing the issue as a redistributive one, i.e. "demoralizing" it such that it no

longer has the characteristics of morality policy (Mooney and Lee 2001). Some types of abortion policy may be more easily defined outside of the morality framework, such as public funding of abortions (see Meier and McFarlane 1993) and Targeted Restrictions of Abortion Providers (TRAP) policies, which place regulations on the licensing or architecture of abortion clinics that are not placed on other comparable health facilities (Medoff and Dennis 2011).

Scholars of abortion policy have argued that because abortion is a "clash of absolutes," people opposed to abortion are uncompromising in their positions (Luker 1984; Tribe 1990). Thus, they are generally opposed to all forms of legal abortion. On the other hand, Democrats often support the passage of restrictive abortion policies that have broader public support (such as bans on late term abortion). Thus, while morality policy variables may have a homogeneous effect across policies, the effect of politics may be heterogeneous.

4.2 Theory and Expectations

Previous studies on the diffusion of state anti-abortion rights policy find different conclusions regarding whether or not theories of morality policy or representation best explain abortion policy. The theory of morality policy predicts that conservative public attitudes towards abortion and larger religious constituencies may explain restrictive abortion policy. On the other hand, some studies emphasize that abortion policies may be explained by partisan and descriptive representation. These explanations are not inherently in competition, and in fact, these theories may be complimentary. I expect that in the aggregate both of these explanations correctly explain anti-abortion rights policies. While some policies may be better predicted by the former and others by the latter, when looking at a significant body of policy that constitutes the state abortion environment, representation and morality policy variables *both* shape anti-abortion policy. Conservative attitudes about abortion may not

matter when Democrats control the legislature. Instead, the intersection of conservative abortion opinion and Republican control of the legislature may create a policy window that is particularly permissive towards conservative policy.

> *Morality Policy and Anti-Abortion Rights: Conservative public opinion on abortion and religious constituencies will have a positive effect on anti-abortion rights policy adoption.*
>
> *Representation Policy and Anti-Abortion Rights: Republican control of the legislature and Republican governors will have a positive effect on anti-abortion rights policy adoption; and Democratic women will have a negative effect on anti-abortion rights policy adoption.*
>
> *Conditional Public Attitudes and Anti-Abortion Rights: The effect of conservative public opinion will be conditional on the strength of Republican control of the legislature.*

The issue of abortion is a "clash of absolutes" (Tribe 1990). Activists on the issue are very passionate because the stakes are high for both sides of the issue. If the "other side" were to win, one group would feel a "real devaluation of their lives and life resources" (Luker 1984, 215). For this reason, the morality policy variables may have a homogeneous effect across all of the policies. Opponents of legal abortion will likely support all restrictive abortion policies. In contrast, partisans are strategic actors and they may focus their efforts on blocking some policies more than others.

> *Faithful Supporters and Anti-Abortion Rights: The morality policy variables will have a homogeneous effect across anti-abortion rights policies.*
>
> *Strategic Partisans and Anti-Abortion Rights: The representation variables will have a heterogeneous effect across anti-abortion rights policies.*

There is no previous literature on the adoption or diffusion of liberalizing abortion policies. It is unclear if pro-abortion rights policies fall under the category of "morality" policy. On the one hand, these policies still regulate abortion and thus the predictors of these policies may be symmetrical relative to anti-abortion rights policies. On the other hand, these policies less cleanly fit within the definition

of morality policy as they usually do not have the same moralistic arguments as restrictive abortion policies. Instead they are often framed in terms of public safety, freedom of speech or religion, or social welfare. If this is the case, the "morality policy" variables of religious adherence and public opinion may be less influential over policy than forces of representation and other state contextual variables. Because the framing of morality policy substantially influences policy diffusion, I expect that liberalizing abortion policies will be poorly explained by the morality policy model.

> *Morality Policy and Pro-Abortion Rights: Conservative public opinion on abortion and religious constituencies will have a weakly negative or insignificant effect on pro-abortion rights policy adoption.*
>
> *Representation Policy and Pro-Abortion Rights: Republican control of the legislature, Republican governors, and women Democrats will have a positive effect on pro-abortion rights policy adoption.*

4.3 Empirical Approach

4.3.0.1 Dependent Variable

I answer the general question of what determines the state abortion policy environment by looking at a near-universe of pro- and anti-abortion policy. By studying many policies simultaneously, I seek to avoid the bias produced by evaluating only specific policies. I collected an original dataset on the state adoption of anti- and pro-abortion rights policies from 1973-2013. These policies were collected from annual reports from NARAL Pro-Choice America (called the National Abortion Rights Action League from 1973-2003). Information from the NARAL annual reports, titled *Who Decides?* have been used in other political science research as a measure of state abortion conservatism or to measure contemporary state abortion policy (such as Arceneaux 2002; Wilcox and Norrander 1999; Berkman and O'Connor 1993). Instead of using only one year as most other scholars have done, I collected these reports from

1989-2014.[2] I supplemented and verified the NARAL reports with publications from the Guttmacher Institute and the National Right to Life Committee (NRLC). The final dataset includes nearly all of the policies tracked by NARAL, the Guttmacher Institution and the NRLC.

A list of these policies, year of first adoption, year of most recent adoption and number of adopted states can be found in Table 4.1. Only the first adoption of a policy by a state is included in the data. Subsequent adoptions of the same type of policy (i.e., repeated events, or when a state that already has a policy adopts a new version of the same policy), are not included in this study. Unlike other projects in which a decision rule is implemented that requires policy adoption by at least 20 states for inclusion, this study incorporates data about policies that are relative "diffusion failures" (those that have diffused to as few as five states). The more lax decision-rule in this study ameliorates, but does not eliminate, the concerns of "pro-innovation bias" (Rogers 1995), namely overstating the effects of geographic proximity and policy complexity and underestimating the effects of interest groups (Karch et al 2013). This approach does not eliminate the potential that there are some other processes not included in the model that contribute to the diffusion of policies that have been adopted by fewer than five states.

The pro-abortion rights policies are substantively very different from the anti-abortion rights policies. While the anti-abortion rights policies often seek significant policy change and have dramatic influence over policy outcomes (i.e. abortion rates or number of clinics), the pro-abortion rights policies generally do not seek substantial changes in policy. Rather, they seek to further codify the status quo or guarantee access to prescription medication or clinics.

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[2]I used the 1989 NARAL report, which is more extensive than subsequent ones, to fill in the adoptions of policy prior to 1989. A second coder also coded a subset of the policies, and the author resolved discrepancies.

Table 4.1: Description of Anti- and Pro- Abortion Policies in the PEHA

Anti Abortion Rights Policy	**First Adopt**	**Last Adopt**	**Nu. of States**
Ban 20 week or earlier	1997	2000	18
Ban 20 week to viability	1973	2013	21
Restrict/Ban Post Viability	1973	2002	32
Mandatory Ultrasound	1996	2012	24
Ban Procedure: IDE	1995	2000	31
Gag Rule	1991	2010	21
Ban Public Facilities	1981	2009	10
Ban Funds Exc Life of Mother	1977	1990	36
Ban Funds Exc Life/Health of Mother	1985	2002	42
Ban Private Insurance	1978	2013	24
Ban Public Insurance	1978	2011	21
Rest. Medical Abortions	2001	2013	18
Require Insurance Waiver	1978	2013	5
Right to Refuse Services	1976	2004	47
Physician Requirement	1973	2002	45
Mandatory Viability Test	1984	1999	6
Parental Notification	1973	2010	24
Parental Consent	1974	2006	28
Informed Consent / Counseling	1973	2013	40
Waiting Period	1973	2011	31
TRAP Licensing	1973	2013	27
TRAP Hospitalization	1973	2013	33
Admitting Privileges	2011	2013	13
Fetal Tissue Disposal	1980	2013	21
Fetal Pain Law	2011	2013	10
Fetal Homicide Law	1970	2013	36
Ban Sex-Selective Abortion	1975	2014	7
'Pro Life' License Plate	2000	2013	33
Ban State Exchange Coverage	2011	2013	22
Pro Abortion Rights Policy	**First Adopt**	**Last Adopt**	**Nu. of States**
Support Medical Abort. Research	1991	2004	5
Funds Available for Low Income	1982	1995	6
Contraceptive Equality	1998	2010	29
Emergency Contraceptive Avail	1997	2009	23
Freedom of Choice Act	1973	2006	7
Guar. Access to Prescriptions	2005	2009	7
Clinic Access Protection	1973	2005	16
Constitutional Protection	1981	2002	17

4.3.0.2 Public Preferences

While it is relatively easy to find time varying measures for all of the key independent variables in this study, except for public opinion. In the previous literature, most scholars have used one of two commonly used static measures of abortion-specific public opinion created through the use of disaggregation.[3] Norrander (2001)

[3]This method pools large numbers of surveys together (usually across many years) and disaggregates to create opinion estimates for states. While this method is easily implemented, pooling policies over many years obscures temporal dynamics.

and Brace et al (2002) pool and disaggregate survey responses to questions about abortion to create a static measure of public opinion.[4] One important concern about these measures is that they does not vary over time. While this is certainly a weakness of the measures, it may not be a fatal flaw given the substantial evidence that abortion opinion has remained relatively flat over time (Wetstein 1996; Norrander and Wilcox 2001; Wilcox and Riches 2002; Jelen and Wilcox 2003; Pacheco 2014).

One dynamic alternative to these commonly used measures of public opinion is Pacheco's (2014) measure of state attitudes toward abortion from 1980-1998 based on dynamic multilevel regression and post-stratification (MRP). MRP uses multilevel regression to predict public opinion as a factor of geographic and demographic predictors, and uses post-stratification to weight estimates for each demographic-geographic respondent type in the actual state population. There are a number of benefits to MRP. This method produces valid and reliable estimates of opinion that outperform aggregation (Park, Gelman and Bafumi 2004) and can be done using as few as 1,400 respondents (Lax and Phillips 2009). Additionally, a dynamic extension to MRP is easily implemented by pooling policies over short time-periods to create rolling averages of opinion (Pacheco 2011; Enns and Koch 2013). Pacheco finds that abortion opinion is fairly stable, with only gradual changes that are homogenous across the states. Using Pacheco's dynamic measure of state attitudes has a significant drawback in regards to this project. Her measure covers a limited time span, and not all states have a measure for all years within that period. Using this measure thus introduces left and right censoring, as listwise deletion in Stata drops all observations for which there are missing data.

I use the same method to create dynamic estimates of state-level abortion

[4]The Norrander (2001) measures are based off Senate National Election Study polls from 1988, 1990, and 1992. The Brace et al (2002) measures are based of General Social Survey responses from 1974-1988.

conservativism that vary over the entire time span of my study. I collected 34 public opinion surveys from the Roper Center that included an identically worded question about abortion and included key demographic and geographic variables. The question used to create abortion opinion is "Do you think abortion should be legal under any circumstances, legal under only certain circumstances, or illegal in all circumstances?" with three response categories of "legal under any circumstance," "legal under only certain circumstances," and "illegal in all circumstances." Responses were coded as 1 = illegal in all circumstances and 0 otherwise.[5] I pooled surveys in 3- and 5-year windows to smooth out the nuances of atypical polls and to increase the sample size to decrease the standard errors.[6]

The variables used to predict abortion conservatism are limited by the type of information available from the Census for the post-stratification step and by the type of information collected in the early opinion surveys. In the multilevel model, I coded data on respondents' sex, race (white/other or black), age category (18-29, 30-44, 45-64, 65+), education (high school education or less, some college, and college graduate), an interaction between age and education, and state (Alabama through Wyoming). I also included a few theoretically motivated state-level predictors of abortion opinion: the percent of the population that is evangelical Protestant or Mormon and the Democratic share in the most recent presidential vote. The multilevel regression equation is thus:

$$Pr(y = 1) = logit^{-}1(\beta^0 + \alpha^{gender}_{j[i]} + \alpha^{race}_{k[i]} + \alpha^{age}_{l[i]} + \alpha^{edu}_{m[i]} + \alpha^{age.edu}_{l[i],m[i]} + \alpha^{state}_{s[i]})$$

[5]I code the polls in this direction for theoretical and methodological reasons. Theoretically, I am interested in that group of responses who has the opinion that abortion should never be illegal. This group may be more likely to actively participate in the issue of abortion, through contacting legislators and raising the salience of the issue. Methodologically, I there may be more movement between the other two response categories. Thus, isolating this response category is more stable across polls.

[6]While only 1,500 responses are needed to create accurate estimates of MRP, it may be more important to minimize the error when creating dynamic estimates.

where:

- $\alpha_{j[i]}^{gender} \sim \mathcal{N}(0, \sigma_{gender}^2)$, for $j = 0, 1$
- $\alpha_{k[i]}^{race} \sim \mathcal{N}(0, \sigma_{race}^2)$, for $k = 0, 1$
- $\alpha_{l[i]}^{age} \sim \mathcal{N}(0, \sigma_{age}^2)$, for $l = 1, 2, 3, 4$
- $\alpha_{m[i]}^{edu} \sim \mathcal{N}(0, \sigma_{edu}^2)$, for $m = 1, 2, 3$
- $\alpha_{m[i]}^{edu} \sim \mathcal{N}(0, \sigma_{age}^2)$, for $l = 1, 2, 3, 4$ and $m = 1, 2, 3$
- $\alpha_{s}^{state} \sim \mathcal{N}(\beta^{relig} \cdot relig_s + \beta^{presvote} \cdot presvote_s, \sigma_{state}^2)$, for $s = 1, ..., 50$

The logistic regression gives the probability that any adult will believe abortion should be illegal in all circumstances given the person's sex, age, race, education, and state. I collected state-level data from the Census that reports the frequency of each person type.[7] I then compute weighted averages of these probabilities (post-stratify) to estimate the proportion of the state that believes abortion should always be illegal. I repeat this process using polls in 3- and 5- year rolling averages (see Tables A.2 and A.3 in the Appendix). In most states public opinion on the issue of abortion has remained remarkably stable, mirroring the pattern seen at the national level. However, there is some variation among the states, with some states seeing an increase in abortion conservatism over time.[8]

Based on previous studies on abortion laws in initiative states, I expect that states with the initiative process may be more likely to adopt abortion policies. The frequency with which states that allow the initiative actually use it varies in accordance with how difficult it is get an initiative on the ballot. I use Bowler and

[7]For example, when all of the independent variables in the model are set to their minimum this represents a white male, age 18-29, with a high school education or less, from Alabama. When all of the variables are set to their maximum, it represents a black woman, age 65+, who is a college graduate, and lives in Wyoming.

[8]A few states do show a decrease in abortion conservatism, for example Massachusetts, however there are not many states that become more liberal and the percent change over the time period is not as large as the increases in abortion conservatism seen in other states.

Donovan's (2004) measure of difficulty of the initiative process, recoded such that values of 1-7 are states that have the initiative (with lower values meaning it is more difficult to get an initiative on the ballot) and 0 for states that do not have the initiative. Coded this way, it can be thought of as *ease of initiative process*.[9]

I use the magnitude of religious adherence in the state as a measure of the strength of religious constituencies. The size of *church adherence* is calculated as the percent of the state population that is a member of a church. While other studies have looked more specifically at the size of the evangelical and Catholic population, I could not find consistently coded data on these groups for the entire time period. Nevertheless, church membership and evangelical and Catholic membership is correlated, and using the more general group is a more stringent test. The percent of the population that is members of a church was collected for each state in 1970, 1980, 1990, 2000, and 2010 from the Association of Religion Data Archives from the Glenmary Institute, and I linearly interpolated the values for the missing years. I also ran models using the size of Catholic adherence; however, the alternative variable did not change the results.

4.3.0.3 Representation

Partisan control of government may be a significant predictor of abortion policy, with Republican control of the state legislature decreasing the probability of pro-abortion rights policy and increasing the probability of anti-abortion rights policy. I include an indicator variable for a *unified Republican control of the state legislative chambers*, the *proportion of Republicans in the legislature*, and *Republican Governor*. Recall that I predicted that descriptive representation may have a significant effect

[9]I also interact these with the measure of public attitudes, to test if the effect of the initiative is limited to states with conservative public attitudes, thereby pushing policy towards public preferences. The interaction is not significant.

on promoting pro-abortion rights policy and preventing anti-abortion rights policy adoption. In this study, the *percent of Democratic women* in each state legislature in each year is calculated from data from the Center for American Women and Politics (CAWP). As hypothesized above, the effects of these partisan variables may vary across policies, which I model using random coefficients (discussed below). I also hypothesized that the effect of public opinion may be conditional on the partisan context. I include an *interaction of abortion conservatism and proportion of Republicans in the legislature.*

4.3.0.4 State Context and Control Variables

States often look to their geographic neighbors when considering a law (Walker 1969, Berry and Berry 1990). According to Mooney (2001b), half of published studies on policy diffusion find a positive and significant effect for regional diffusion. As the proportion of geographic neighbors who have previously adopted a policy increases, so too will a state's probability of adoption. In this study, regional effects are accounted for with a measure of *geographic contiguity*, which is calculated as the percent of neighboring states that have previously adopted a given policy.

In the first year after the landmark *Webster* (1989) decision, there were nearly 400 anti-abortion bills introduced in state legislatures as part of the anti-abortion rights movement's strategy of "bold incrementalism" (NARAL Who Decides, 1991). In order to account for the dramatic increase in policies adopted after this case, I include an indicator variable for *post-Webster decision* years. The passage of time is also an important component in the story of abortion policy diffusion. Time polynomials are used to account for duration effects. These are included in the form of *number of years* since the first state adopted a given policy and, to account for nonlinear time trends, the *number of years squared*.

Although scholars of morality policy find that the "usual suspects" of policy

diffusion do not apply to abortion policy diffusion (see for example, Mooney and Lee 1995), state demographics such as population size and median income are associated with policy adoption more generally and thus may be significant in this analysis. I include the *state median income* and *population size* from the decennial census and linearly interpolate the missing data.

4.3.0.5 Modeling Strategy

Since Berry and Berry's (1990) study of state lottery adoptions, event history analysis (EHA) has been the standard approach to modeling policy diffusion. EHA allows scholars to simultaneously account for both internal and external determinants of policy adoption. However, the policy-specific EHA approach emphasizes the unique determinants of specific policy instead of engaging in a broader discussion of government learning (Grossback, Nicholson-Crotty, Peterson 2004; Boehmke 2009). A scholar looking at only a single policy may find a variable to be significant, but the same variable may not be a significant predictor of other policies relating to the same policy arena. For an example drawn from the case of abortion policy, a non-controversial and highly salient policy such as one that mandates parental consent may be less influenced by political variables and more influenced by public opinion than policies that garner less public support. Including many policies in a single analysis helps scholars avoid making conclusions about general policymaking from an anomalous policy.

Pooled event history analysis (hereafter PEHA) allows researchers to study the effects of variables across multiple policies by stacking the data and estimating the parameters in a single model (Boehmke 2009; Makse and Volden 2011; Shipan and Volden 2006). This approach is more parsimonious than estimating separate models for each policy, allows the research to establish commonalities between different policies and to leverage information about policies with few adoptions. This

method builds on the standard EHA approach, in which the dichotomous dependent variable is coded as a 1 for the time period in which a policy is adopted; 0 when it is in the "risk set" of states that has not adopted the specific policy; and "missing" for years after the policy has been enacted. Specifically, Y_{it} is an indicator variable for if state i adopts a policy in year t. In a PEHA model, the unit of analysis is the state-policy-year and the dependent variable includes a subscript for the specific policy K, so that Y_{itk} is an indicator variable if a state i adopts a policy k in year t. States remain "at risk" for adoption until the policy is enacted. As such, Y_{itk} is coded as 0 when the state is "at risk" to enact a policy; coded as 1 the year of adoption; and coded as "missing" for subsequent years. Only the first adoption is coded - subsequent adoptions in a state of the same law are not modeled here (for example, if a state with a mandatory waiting period law adopts a new mandatory waiting period law). In a standard EHA model, a state is no longer in the dataset once it has adopted a policy. Here, the state remains in the set until all policies have been adopted by that state.

In PEHA, the policies can be defined as groups, with state-year observations as units within the policy groups. I use multilevel modeling to account for the correlation of errors within groups and to explicitly model the heterogeneity of effects for certain variables across policies. In Monte Carlo simulations testing strategies for modeling heterogeneity in PEHA, multilevel modeling out performs clustering and fixed effects models, yielding the best combination of unbiased estimates and standard errors ([Author's Name] 2014). In taking this approach, I allow the intercept and the partisan variables to vary. This is important because the baseline probability of adoption may vary across policies. Some policies may be adopted by more states, holding constant other factors. For example, the Right to Refuse Services was adopted in 47 states, but Mandatory Viability Testing was adopted by only 5 states (see Table 4.1). Partisan forces may focus their attention on certain policies and make

strategic concessions in regards to others, so I include random coefficients for these variables.

This method of modeling the adoption of policies with PEHA has several noteworthy drawbacks. Methodologically, pooling this many policies together almost certainly violates some assumptions about homogeneity. I use multilevel modeling to model heterogeneity with random intercepts and random coefficients with policies as the group level variable. However, this method does not correct for correlation among observations. It is likely that the probability of adopting one policy may be correlated with the adoption of a similar type of policy. It also assumes that variance is constant across the policies. Substantively, this approach emphasizes finding the *average* determinants of policy adoption over nuanced learning about specific policies.

4.4 Discussion of Results

I estimated separate models for the pro- and anti- abortion policies from 1973-2013 using discrete pooled event history analysis with variables drawn from the morality policy and representation literatures (Table 4.2 and 4.3). The random intercept coefficients are significant for policies in the anti-abortion rights models, indicating that there are variation in the baseline probability of adoption across policies.[10] Policy adoption in general is a rare event. This is especially true in the analysis here, in which I include policies that have diffused to as few as 10% of the states. In the anti-abortion rights models, the dependent variable "fails" (i.e., is coded as a 1) in only 2.35% of the data and 1.23% in the pro-abortion rights models. Therefore, even effects that appear small may have a significant substantive effect.

[10]See Figure A.4 in the appendix for a graphical representation of the random intercepts.

Table 4.2: PEHA Estimates of Diffusion of Anti-Abortion Rights Policies, 1973-2013

	M1	M2
	Anti - Base	Anti - Interaction
Policy Adoption		
Abortion Always Illegal	0.010	-0.069**
	(0.012)	(0.033)
Religious Adherence Rate	1.466***	1.397***
	(0.391)	(0.388)
Prop. of Republicans	0.410	-2.348**
	(0.376)	(1.114)
Unified Republican Legislature	0.130	0.163
	(0.137)	(0.139)
Republican Governor	0.262**	0.248*
	(0.127)	(0.128)
Prop. of Women Democrats	-6.750***	-7.150***
	(1.399)	(1.417)
Inter: Prop. Repub. Leg * Opinion		0.150***
		(0.058)
Ease of Initiative	0.065***	0.065***
	(0.019)	(0.019)
State Median Income	-0.000**	-0.000***
	(0.000)	(0.000)
State Population	0.000*	0.000*
	(0.000)	(0.000)
Prop. Neigh. Prev. Adopt Pol.	2.000***	2.024***
	(0.180)	(0.180)
Years Since First State Adopt Policy	-0.084***	-0.086***
	(0.019)	(0.019)
Years Squared Since First State Adopt	0.002***	0.002***
	(0.000)	(0.000)
Indicator: Post-Webster Era	0.709***	0.735***
	(0.162)	(0.162)
cons	-4.396***	-2.780***
	(0.408)	(0.740)
var(Women Democrats)	14.235*	14.805*
	(8.324)	(8.572)
var(Republican Governor)	0.192*	0.195*
	(0.108)	(0.109)
var(Constant)	0.339**	0.344**
	(0.167)	(0.170)
N	28366	28366
χ^2	277.13	283.25
aic	5428.99	5424.28
bic	5569.29	5572.84

Note: single tailed-tests, * p<0.01, ** p<0.05, *** p<0.01.

Table 4.3: PEHA Estimates of Diffusion of Pro-Abortion Rights Policies, 1973-2013

	M3 Pro - Base	M4 Pro - Interaction
Policy Adoption		
Abortion Always Illegal	-0.055	-0.046
	(0.034)	(0.095)
Religious Adherence Rate	-1.939*	-1.931*
	(1.053)	(1.057)
Prop. of Republicans	-0.391	-0.103
	(0.938)	(3.080)
Unified Republican Legislature	-0.923***	-0.919***
	(0.342)	(0.344)
Republican Governor	-0.228	-0.226
	(0.253)	(0.254)
Prop. of Women Democrats	4.527	4.538
	(2.918)	(2.921)
Inter: Prop. Repub. Leg * Opinion		-0.019
		(0.193)
Ease of Initiative	0.069	0.069
	(0.050)	(0.050)
State Median Income	0.000***	0.000***
	(0.000)	(0.000)
State Population	0.000***	0.000***
	(0.000)	(0.000)
Prop. Neigh. Prev. Adopt Pol.	0.492	0.495
	(0.456)	(0.458)
Years Since First State Adopt Policy	-0.051	-0.051
	(0.043)	(0.043)
Years Squared Since First State Adopt	-0.002*	-0.002*
	(0.001)	(0.001)
Indicator: Post-Webster Era	0.957**	0.958**
	(0.436)	(0.436)
cons	-4.556***	-4.705**
	(1.101)	(1.874)
var(Women Democrats)	24.692	24.778
	(19.852)	(19.922)
var(Republican Governor)	0.114	0.113
	(0.216)	(0.216)
var(Constant)	0.259	0.259
	(0.340)	(0.340)
N	8149	8149
χ^2	72.39	72.20
aic	994.47	996.46
bic	1113.56	1122.56

Note: single tailed-tests, * p<0.01, ** p<0.05, *** p<0.01.

4.4.0.6 Morality Policy Predictors

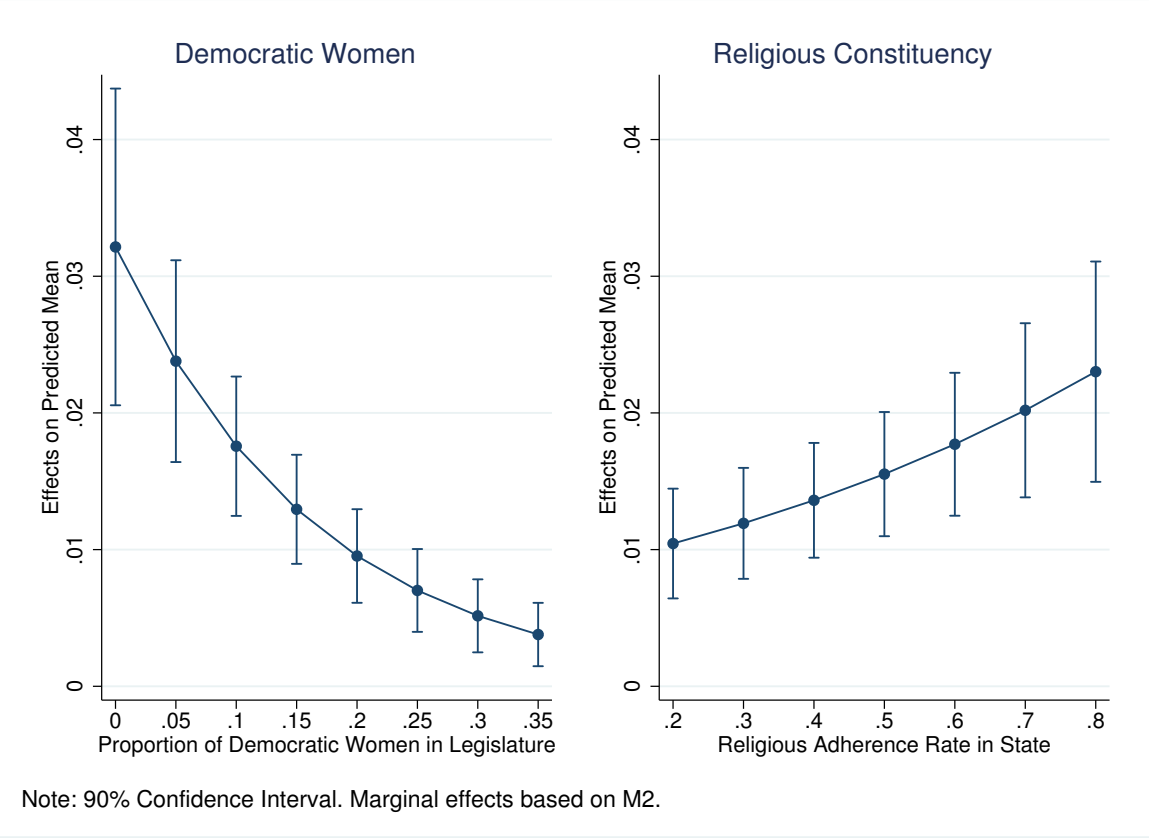
At first glance, it is apparent that there are more predictors of anti-abortion rights policies relative to pro-abortion rights policies in Models 1 and 3 of Table 4.2 and 4.3. The religious adherence of state constituents is a significant predator of both types of policy, though the significance and substantive effect is much larger for the restrictive abortion policies.[11] The marginal effect of religious constituencies (shown in Table 4.1) is substantial. As religious adherence in the state increases from the minimum to the maximum, the marginal effect also doubles from .011 to .023. The marginal effect of religious constituents is also substantively significant for pro-abortion rights policies, changing from the .003 .009.

The influence of conservative public opinion is much narrower than expected, and there is no main effect of conservative state attitudes on abortion for either pro- or anti-abortion rights policy. The probability of adopting restrictive abortion policies is lower in states with no initiative than the states with the lowest threshold for getting a ballot on the initiative (.016 compared to .028). Unlike some other studies of abortion policy congruence, models that included an interaction of the initiative variable and conservative public opinion were not significant.

These findings are mostly consistent with the expectations of the *Morality Policy and Anti-Abortion Rights* hypothesis; the religious beliefs of people in the state influence the adoption of policies that restrict legal abortion. However, unlike expectations, there is no significant effect of conservative public attitudes towards abortion. In alternative specifications not shown, I find that the effects of religious

[11]There are some evidence that Catholic and Evangelical christians supported limited legal abortion until the early 1980s, and that opposition to abortion was not solidified until the late 1980s. In order to test if religious constituencies have a differential effect across the time period, I ran models with an interaction between religious constituencies and the indicator variable for years after the Supreme Court case *Webster* (1989). This interaction was not significant. These models are available from the author upon request.

Figure 4.1: Marginal Effects of Key Variables on Anti-Abortion Rights Policy



Note:Marginal effects based on M2 in Table 4.2.

constituencies and public opinion are homogeneous across policies, confirming the *Faithful Supporters* hypothesis. In these models, I include random coefficients for public opinion and religious adherence in lieu of the partisan variables in Models 1-4, but the coefficients do not achieve statistical significance.[12] This suggests that the conservative values of state residents consistently effect the likelihood of adopting different conservative abortion policies.

However, there is also some indication that policies that increase access to abortion rights may not be well explained by the typical morality policy variables, confirming the *Morality Policy and Pro-Abortion Rights* hypothesis. Religious constituencies do decrease the probability of adopting liberal policies, but this effect is only marginally significant. This makes theoretical sense. If morality policy is characterized by technical simplicity and framed in terms of core values, the most common liberalizing policies do not really fit the bill (see Table 4.1 for a list of the policies). Instead, they are framed in terms of safety, equal access to medical care, or free speech. Despite regulating access to abortion, which is almost universally considered a morality policy, liberalizing abortion policies are not "moral" in nature.

4.4.0.7 Representation Predictors

There is also support here for a story of partisan and descriptive representation. I include random coefficients for two of the three partisan variables in the models, to allow the effect of these partisan forces to vary across policies.[13] I find that unified Republican legislatures have a significant and negative effect on the probability of liberal, but not restrictive, abortion policies. Interestingly, the strength of Republican

[12]These models are not shown here, but are available upon request from the author.

[13]The coefficient for Republican legislature did not achieve statistical significance. Because running models with multiple random coefficients is computationally taxing, the random effect for Republican legislatures was removed from the final model.

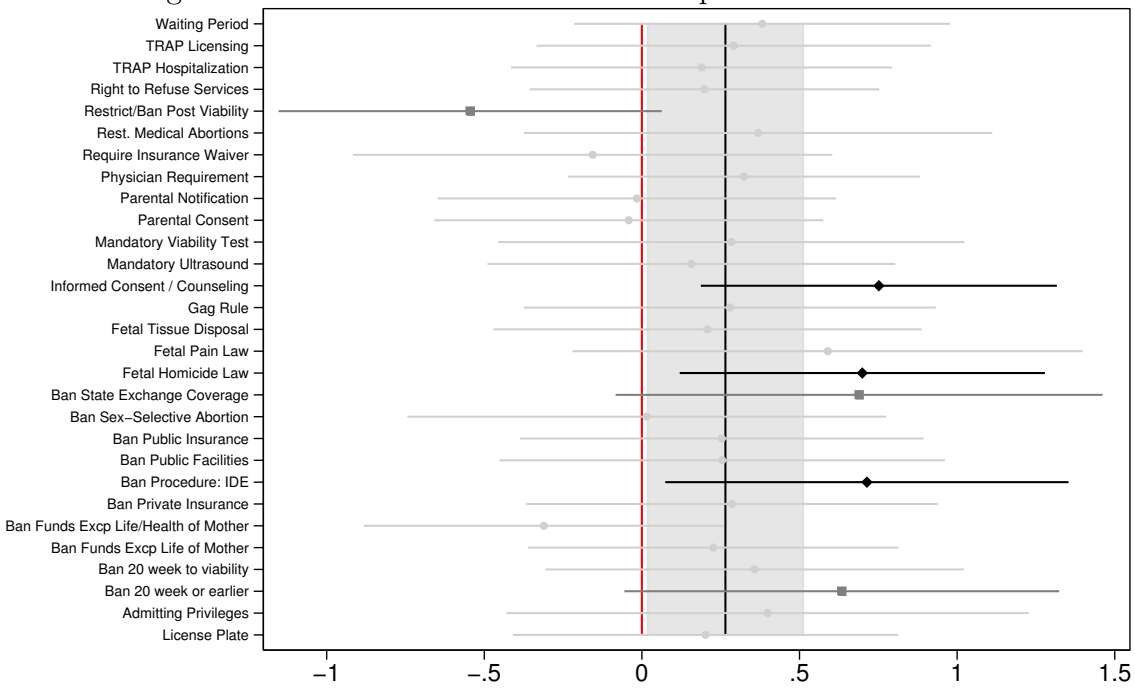
control of the legislature, measured by the proportion of Republicans, does not have a significant main effect for either type of policy. [14]

Partisan control of the executive branch does have a significant effect on anti-abortion policy adoption, increasing the simulated probability of adoption from .016 to .022. There is variance around the strength of this effect. Not only is the *average* effect of Republican governors statistically significant, it is also significant at the $p<0.05$ level for three policies, and at the $p<0.10$ level for three more. Figure 4.2 graphs the standard deviation for the random coefficients for Democratic governor. The black vertical line and shaded grey region show the average effect of Democratic governors and the 95% confidence interval. The black and dark grey horizontal lines show the effect on specific policies that are significant at the $p<0.05$ and $p<0.1$ level respectively. The policies for which Republican governors have the strongest effect are highly salient, partisan policies: mandatory counseling, policies that assert that fetuses feel pain and require anesthesia, and the banning of the specific procedure Intact Dilation and Extraction.[15] Republican governor's also have a significant effect on the adoption of policies that ban abortion coverage in healthcare exchanges and bans on abortion pre-viability. Republican governors, somewhat surprisingly, decrease the probability of a state adopting restrictions or bans on post-viability abortion. However, this makes sense given that states with Republican governors are more likely to adopt policies that ban abortions pre-viability (making the ban or restriction of post viability abortions unnecessary). The lack of significance on the effect of

[14]Because the parties did not have distinct stances on abortion until the late 1980s, I ran models with an interaction term for Democratic control of the state legislature and the indicator variable for years after the Supreme Court case *Webster* (1989). This interaction was not significant. This model is available from the author upon request.

[15]Mandatory counseling or informed consent laws are often called "Women's Right to Know Acts" and the intact dilation and extraction procedure called "partial birth abortion" by opponents to legal abortion.

Figure 4.2: Estimated Coefficients for Republican Governors



Notes: Points represent the combined fixed and random effect for each variable for each policy. Lines represent a 95% confidence interval based on the combined standard errors of the fixed and random effects. Black cases with diamonds are significantly difference from zero at the .05 level; medium gray cases with squares are significantly different at the .10 level; and light gray lines with circles are not. Vertical black line indicates the estimated fixed coefficient for that variable and the light shaded region gives its 95% confidence interval. Vertical grey line indicates zero.

Republican governors on liberal abortion policy is not particularly surprising given that Republican governors rarely use their veto power to stop these policies.

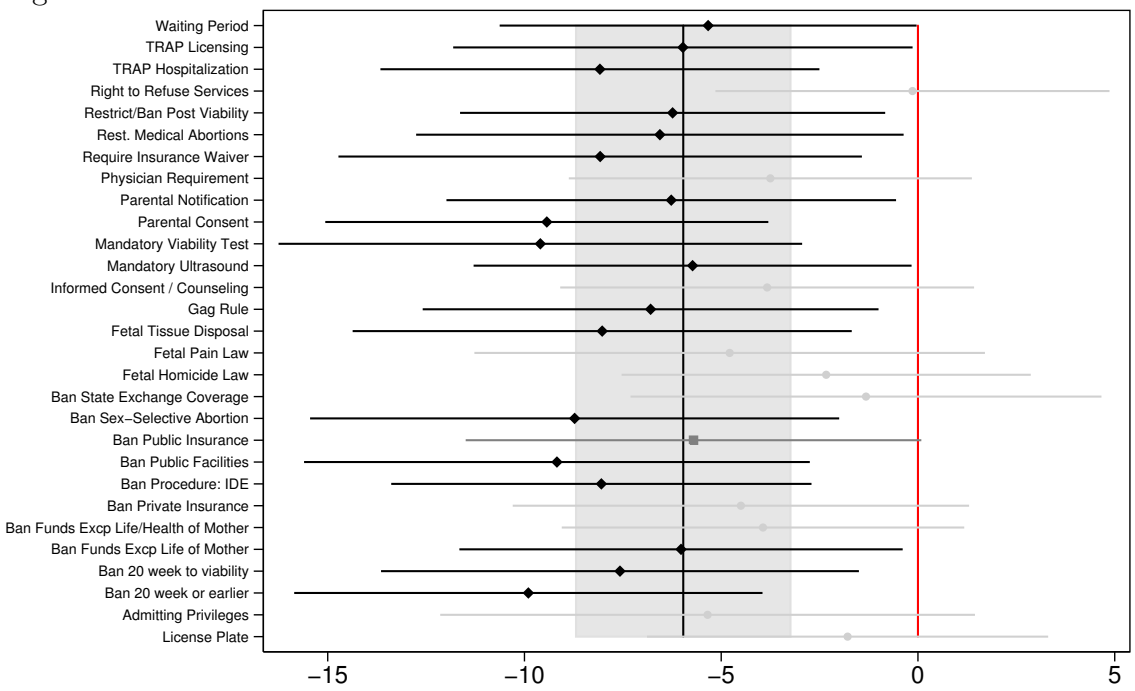
The issue of restrictive abortion policy is not just a partisan issue; it is also a gender one. Consistent with the previous literature, the percent of the state legislature comprised of Democratic women has a significant effect on anti-abortion policy adoption. As the proportion of Democratic women in the legislature increases from the minimum to the maximum of 35.4%, the marginal effect decreases substantially from .033 to .004. Somewhat unexpectedly, I find that pro-abortion rights are just partisan, and not gendered, policies. States with many Democratic women are no

more likely to adopt liberal abortion policies than states with no Democratic women.

The effect of women Democrats on anti-abortion policies is heterogeneous across policies. This variance is significant at the $p<0.05$ level for 21 policies and at $p<0.01$ for four more policies (see Figure 4.3). Democratic women have the strongest effect on policies that place bans on gestational bans (20 weeks or earlier), mandatory viability testing, mandatory parental consent for minor women, bans on public insurance coverage of abortions, and sex-selective abortions. The effect of Democratic women is also not significant for some symbolic anti-abortion rights policies, such as the one that allows for special "Pro-Choice" license plates or declare that physicians have the "right to refuse service" to women seeking an abortion. License plate laws are relatively non-controversial and low in salience, and the initial diffusion of conscious clause policies (the service refusal laws) was rapid and before many women were in state legislatures. Unlike the random coefficients for Republican governor, which were inconsistently signed, the effect of Democratic women is never positive. An increase in the proportion of Democratic women in the state always decreases the probability of anti-abortion rights policy adoption (although this decrease is not always statistically significant).

These findings provide mixed support for the *Representation and Anti-Abortion Rights* and *Representation and Pro-Abortion Rights* hypotheses. Republican governors and Democratic women are significant predictors of restrictive abortion policy but there is no main effect for Republican legislatures. Republican legislatures are a significant predictor of pro-abortion rights policies, but Democratic women and Republican governors are not. The *Strategic Partisans* hypothesis is also confirmed; there is significant variance around the effect of Democratic governors and Democratic women on anti-abortion policy. These actors are strategic, in that they focus their effort on some anti-abortion policies more than others.

Figure 4.3: Standard Deviation for Random Coefficients for Democratic Women



Notes: Points represent the combined fixed and random effect for each variable for each policy. Lines represent a 95% confidence interval based on the combined standard errors of the fixed and random effects. Black cases with diamonds are significantly difference from zero at the .05 level; medium gray cases with squares are significantly different at the .10 level; and light gray lines with circles are not. Vertical black line indicates the estimated fixed coefficient for that variable and the light shaded region gives its 95% confidence interval. Vertical grey line indicates zero.

4.4.0.8 Conditional Effect of Public Opinion - When Do Public Preferences Matter?

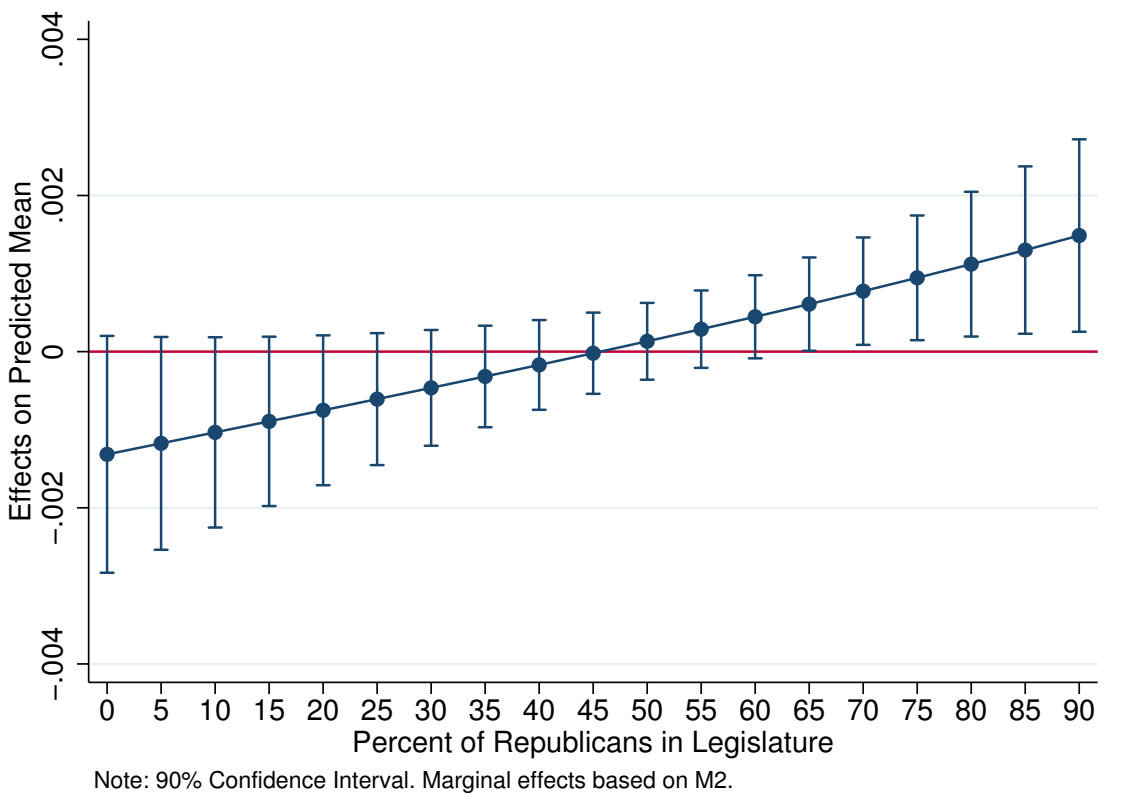
There is no main effect for either public attitudes on abortion or the proportion of Republicans in the legislature on the adoption of abortion policies. However, there is a significant interaction of public preferences and the partisan context for anti- abortion rights policy but not pro-abortion rights policy (see Models 2 and 4 in Table **??**), confirming the *Conditional Public Attitudes* hypothesis. When public attitudes are interacted with the size of the Republican delegation, both base terms are significant and negative and the interaction term is positive. What this means substantively can be seen in Figure 4.4. The marginal effect of conservative public opinion is positive when the percent of Republicans in the legislature exceeds 45% and this effect becomes statistically significant when the percent of Republicans exceeds 65%. Conservative public opinion doesn't matter when Democrats control the legislature. Instead, the effect of conservative opinion increases as the size of the Republican delegation in the legislature increases.

4.4.0.9 Controlling for Other Explanations

At least in the case of anti-abortion policies, states are more likely to adopt a given policy as the percentage of their neighbors that have previously adopted a policy have already done so. Somewhat surprisingly, there appears to be no regional clustering among pro-abortion rights policies. Why is regional diffusion a significant predictor of only one of these types of policies? This is an interesting question that cannot be fully addressed here, but may be a promising question for future research.

The three variables that incorporate the temporal context are also significant predictors of abortion policy adoption. Both types of policies are significantly more likely to be adopted after the Supreme Court case *Webster* (1989), which allowed states to regulate abortion in the first trimester of pregnancy. In the models for

Figure 4.4: Conditional Effect of Conservative Opinion on Anti-Abortion Rights Policy



Note: Marginal effects based on M2 in Table 2.

anti-abortion policies, both the number of years since the first state adopted a given policy and the number of years squared are significant, indicating that the diffusion of anti-abortion policies follows a quadratic pattern. The probability of adoption first decreases and then increases. There is also a non-linear time trend for the pro-abortion rights policies - in these models, the time squared variable is negative and marginally significant. Interactions with time variables (both the number of years and the indicator variable for years after 1989) and public attitudes or the partisan variables were not significant. The state population is significant in all models, indicating that both restrictive and liberalizing abortion policies are more likely in populous states.

4.4.0.10 Robustness Check

To ensure that the findings discussed above are similar even when the data used to test the model are different, I ran each of the models again with two different decision rules regarding policy failures (see Table **??** in the Appendix). When I dropped all policies that had diffused to fewer than 10 states, the percent of the dataset that "failed" increased to 2.78% for anti-abortion policies and increased to 1.55% for pro-abortion rights policies. When I dropped all policies that had diffused to fewer than 20 states, the percent of the dataset that "failed" increased to 2.94% and 2.82% for pro-abortion rights policies. Very little changes across models of anti-abortion rights policy. The level of significance of conservative opinion, Republican governors, and the interaction term changes, but the magnitude of the coefficients is very similar across models. There are more differences across models of pro-abortion rights policy, likely because there are far fewer of these policies that have diffused to many states. There are only four policies that diffused to more than 10 states and only two policies that diffused to more than 20.

4.5 Conclusion

The proliferation of hundreds of abortion policy adoptions across the states in the last few decades is an important puzzle for political scientists. Based on the existing literature, we do not have a coherent idea of why states are adopting these policies and where we can expect them to be adopted in the future. Scholars studying different abortion policies at different points in time and focusing their research on different causal narratives have come to conflicting conclusions about the determinants of abortion policy. This chapter uses pooled event history analysis to conduct the first comprehensive examination of the near-universe of pro- and anti-abortion rights policy, from 1973-2013.

I find that both morality policy theory and the state political context go far in shaping the state abortion environment, though pro-abortion rights policy is less well explained. Religious constituencies increase the probability of adopting conservative abortion policy and decrease the probability of adopting liberal policy. Partisans in government shape the policies in different ways. Republican governors increase restrictive policies and Republican legislatures decrease liberal policies. Conservative attitudes about abortion are significant, but only when the legislature is also conservative. Surprisingly, Democratic women only shape conservative abortion policy - they have no significant effect on pro-abortion rights policies.

This chapter makes three unique contributions to the political science literature. First, this paper uses an original dataset of nearly 40 different abortion policies. Some of these policies have already been used in previous work, but for most of these policies it is the first time their adoption has been studied in academia. The dataset includes policies that regulate the funding of abortion, administrative hurdles, physical plant requirements, gestational and procedure bans, and policies that seek to maintain or increase access to legal abortion. This paper also shows the creation

of a key variable that explains abortion policy. While the previous literature relied on static measures of abortion-specific public opinion, I create dynamic state-level estimates of public opinion that vary over time.

I use this extensive dataset and an approach to studying policy diffusion that seeks to find the average determinants of policy to resolve conflicting findings in the existing literature. By pooling many policies into a single analysis, I am able to show that *on average* both morality policy and representation explanations of anti-abortion rights policy adoption are correct. This approach can be used to determine the average policy environment for different policy arenas. For example, Taylor et al. (2012) run 14 separate event history analyses of state non-discrimination policies that include gender identity and sexual orientation. They find that the determinants of these policies vary depending on the content and scope of the policy in question. Future work could employ PEHA on the full set of policies (or a theoretically motivated subset, such as the seven that relate to gender identity) to establish the average determinants of non-discrimination policy in the states.

Finally, the project highlights the role politics play in shaping access to legal abortion. I find that unified partisan control of the state legislature and party of the executive are significant predictors of abortion policy. This finding is important in light of long-term trends in polarization. According to the National Council on State Legislatures, there were only three states with divided legislatures in 2012, the lowest number since 1928.[16] One of the most surprising findings in this study is that while Democratic women are one of the most significant predictors of conservative abortion policy, they had no significant effect over policy that further codified the status quo or expanded access to legal abortion. It seems that Democratic women

[16]In 2012, four states had divided legislatures (IA, KY, NH, and VA), but the lieutenant governor in Virginia casts the tie-breaking vote, so it can be considered a unified Republican legislature.

are more effective at blocking "hostile" policies than passing liberal ones.

Although this study helps to settle a debate in the literature and establish the average determinants of abortion policy, there are tradeoffs in using pooled event history analysis to study the diffusion of policy. In this work, I seek parsimony at the expense of a detailed explanation of the diffusion of different abortion policies. By establishing the *average* determinants of policy, the method by definition ignores these nuances. And like any event history analysis, it establishes correlations but cannot make strong statements about causality. This project is also limited by the static measure of state abortion opinion. While evidence suggests that abortion opinion is stable at the state level in the 1980-90s and stable over the entire time period at the national level, I make an assumption here that opinion in the states is also stable for the full time period. I find that a static measure of conservative public opinion is a significant predictor of both pro- and anti-abortion rights policy, but I am not able to make a strong statement about the effect of public opinion over time. Future research should seek confirmation of this assumption by creating dynamic measures of state abortion opinion.

CHAPTER 5
IMPLEMENTATION

Many of the most stringent abortion policies in the states are ones in which the state effectively forces clinics to close or stop providing abortions. In doing so, they significantly influence women's access to abortion services in certain regions. These exacting policies impose specific licensing, reporting and facility architectural requirements and are known by a variety of names.[1] Interestingly, these increasingly popular policies sometimes originate outside the legislature.

In order for a state agency to implement a policy, it must be directed and granted authority to do so by the state legislature. The agency's purpose is to create rules and regulations to fill out the details of the policy, and to create a structure necessary to implement the policy. The existing literature establishes a variety of factors that determine the amount of discretion the state legislature grants to the bureaucracy to create these rules. The length of the text in state statutes is frequently used to measure this discretion. While this is typically how bureaucracies are involved in policymaking, this is not always the case.

In the case of state abortion policies, some state agencies take initiative to make significant policy change without being directed or given specific authority to do so. By using existing regulating authority, state health boards can effectively create new policy outcomes by adding or amending rules. State agencies, such as health boards, are filled with appointed officials not elected by the people, and the board meetings are generally poorly attended. This means that important policy is created in a venue in which the policymakers are not electorally responsive to

[1]This category of bills includes requirements such as ones that abortion providers must have admitting privileges in local hospitals, that clinics be classified as ambulatory surgical centers, etc.

the public, the appointed bureaucrats and the executive that selected them are very influential, and where the policymaking stage is removed from the public's attention.

The existing research on state bureaucracy focuses on the conditions under which legislatures grant bureaucratic discretion. This approach to studying the bureaucracy provides a useful starting point for this project, but is unable to capture the key question of this chapter. That is, how and why do state bureaucracies make significant policy change when the legislature has not passed a law directing them to do so? How do bureaucracies "make policy" outside of their traditional legislative purview? In order to address these questions, I conduct an exploratory case study that follows bureaucratic activism in three states: the telemedicine abortion ban in Iowa, an insurance coverage ban in Georgia, and abortion clinic regulations in Virginia. A detailed look at health boards in three states that adopted different abortion policies points to conflicts in the state legislative environment, the role of the Governor and other executive branch leaders, and the participation of active interest groups as the explanation for extra-legislative policy making.

5.1 The Study of Bureaucracies in the States

Bureaucratic rules and regulations are very common. Bureaucratic policymaking has increased in recent years as the productivity of Congress has decreased. In the last few decades, federal agencies adopted 10 times as many rules as Congress passed laws (Conglianese 2004, 5). Despite having significant influence over policy, bureaucrats are typically appointed to their positions and not elected by the people.

The process by which bureaucrats are selected varies across the states, and varies within the states depending on the specific agency. In most states, the people directly elect the leaders of the executive branch (the governor, lieutenant governor and secretary of state). Going down the ranks within the executive, there is more state variation. For example, the office of attorney general is elected in 35 states.

The governor or an agency head typically appoints the lower level bureaucrats, like the ones that serve on the boards that oversee education, environmental protection, health, or social services. The governor usually appoints members of the state health board. In most cases, members of the board then must get confirmed by some part of the state legislature, but it isn't uncommon for the confirmation or appointment to be done by the agency head (Book of States, 2014). In 11 states, the appointment does not require a confirmation.

The governor's role in selecting agency heads and board members ensures that the chief executive in the state has substantial influence over who fills these positions. Executives fill positions in the bureaucracy with like-minded individuals. Thus, the partisanship and ideology of the executive influences the race, gender and ideological composition of executive offices (Meier and Stewart 1992; Keiser, Wilkins, Meier and Holland 2002; Dolan 2002; Clark, Ochs, and Frazier 2013).

How much the individuals in the bureaucracy or groups lobbying the bureaucracy can shape policy is contingent on the amount of discretion they are granted to implement a policy. If the legislature does not grant much discretion, then the composition of the agencies matters less. A substantial body of work investigates under what conditions the legislature grants more discretion to the bureaucracy. When there is divided party government (a different party controlling Congress and the presidency), legislatures enact longer policies with more detail, granting less discretion to the bureaucracy (Epstein and O'Halloran 1999; Huber and Shipan 2002). The extent to which state legislatures are able to create longer statutes is also dependent on several other conditions, such as the political context (whether legislators and agencies agree, partisanship, etc.), the professional capacity of the legislature, and the ways in which the legislature can control the bureaucrats (Huber, Shipan, and Pfahler 2001).

The existing research helps to build an understanding of under which conditions the bureaucracy has more leeway to implement policy. It also establishes how

the preferences of the bureaucracy can be affected by the composition of the agency when there is discretion. What is missing in the existing literature is how bureaucracies enact policy change unprompted by the legislature by taking advantage of the broad authority already granted to them. Under what conditions is this sort of bureaucratic activism likely, and how is the bureaucracy able to enact policies when the legislature in unable to do so?

5.2 Expectations

In building an explanation for when bureaucracies make policy without legislative instruction, I seek to investigate the following three influences. First, I see to establish a pattern of **political conditions** that precipitate and shape bureaucratic action on the issue of abortion. Members of the state boards are appointed by the governor or by the governor-appointed agency heads. Bureaucratic policymaking may be more likely when the governor places the issue of abortion prominently on the *governor's political agenda.* Bureaucratic policymaking may be even more likely when the governor's party faces repeated legislative failures. When the governor's party *fails to get enough votes* to pass a bill or *key actors block legislation,* the governor may encourage the bureaucracy to implement a similar policy. This legislative conflict may not be one between parties; the conflict may be between co-partisans in different chambers, or a clash with party leadership. Once the bureaucracy has implemented a new rule regarding abortion, it becomes the new policy status quo. Bureaucratic rules may be more vulnerable to future change, so the legislature may want to *codify the board's rules.* The legislature will have more success enacting a statutory abortion restriction once the bureaucracy has already implemented it using rhetoric that emphasizes the bill does not change the status quo.

Second, I seek to understand the involvement of two groups of **non-legislative actors**. The public does not have a mechanism to force the bureaucracy to be respon-

sive to its preferences; however, the *public commenting period* in which the public can submit comments and publicly testify is a required part of the rulemaking process. The public comment period is intended to be an opportunity for the public's voice to be heard, but because the public does not elect the boards, I do not expect the content of the public comments to significantly influence agency decisions. *Interest groups* also participate in the commenting period, petition agencies, and mobilize public support. Abortion interest groups are well funded and very active in lobbying the legislature and governor, so I expect them to be involved in lobbying the bureaucracy. Professional physicians associations have a vested interest in the implementation of health board licensing and reporting requirements, so will also be active participants in the rulemaking process.

5.3 Description of Method and Selection of Cases

This is an exploratory chapter intended to establish patterns that can be further evaluated in future work. By tracing the process of abortion rulemaking process in three states, I explore the ways in which different actors are involved in the policymaking process. The method of qualitative case study is a particularly useful way to generate theory about a political process that is not well understood. In depth-case studies allow the researcher to document nuances of the case that may be lost in a large-n quantitative analysis.

I explore three cases of abortion rulemaking using a most-different-system-design (MSDS). The MDSD, which is based in Mill's (1846) method of similarity, consists of comparing very different cases. The intuition behind the MSDS is that when one compares very different cases that all have the same dependent variable, then the common patterns can be regarded as a key independent variables (Przeworski and Teune 1970). In the research presented here, I explore the adoption of rules in three states, with different health agencies, adopting different types of abortion

policy. The goal of this case-oriented strategy is to better understand the complex and dynamic rulemaking process rather than establish relationships between variables (Ragin 2000).

The three states evaluated here have boards that cover different jurisdictions, are appointed in a different process, and are subject to different terms. The nine members of the Iowa Board of Medicine (IBM) are appointed by the governor and confirmed by the Senate to serve three-year terms. The IBM oversees issues of public health and safety, regulates physicians and surgeons (M.D.s), osteopathic physicians and surgeons (D.O.s) and licensed acupuncturists (L.Ac.s). The Georgia Board of Community Health (BCH) also has nine members, who are appointed to six-year terms by the governor. The BCH governs the Department of Community Health (DCH), which is one of Georgia's four health agencies. The DCH oversees the state health insurance plan, regulates healthcare facilities, and health information technology. The Virginia Board of Health has 15 members appointed to four-year terms. Their appointments are made by the governor and confirmed by both legislative chambers. The core functions of the Board include advising the governor on health-related issues, implementing state statutes, identifying health-related issues and formulating policy, education, advocacy concern health care reform, and advancing the public's quality of life through improving health.

The three cases concern three different abortion policies, all of which are becoming increasingly common policies in the states. In Iowa, the IBM enacted a rule that banned the practice of telemedicine by changing the language used to implement an existing statute requiring that an abortion be conducted by a physician to instead require the physical presence of a licensed physician. The Georgia BCH stopped the state-funded insurance plan's coverage of abortion by changing the benefits coverage when it selected a new insurance provider. The state legislature directed the Virginia Board of Health to enforce new facility requirements for abortion clinics, but in

writing the regulations, decided to no longer exempt existing facilities from the new standards.

5.4 Telemedicine Abortions in the State of Iowa

Thirty-nine states require that only a licensed physician may perform an abortion. Most of these laws date back to the 1970s, when surgical abortions posed greater risks, and medical abortions were not yet legal. At the same time, the number of abortion providers is dwindling. According to the Guttmacher Institute about 50% of Iowan women between the ages of 15-44 live in one of the 85% of Iowa counties without an abortion provider. Nationally, 87% of counties nationally do not have an abortion provider, leaving 34% of women of childbearing age in a county without access to abortion. New "Targeted Regulations for Abortion Providers" (often called TRAP laws) dramatically increase the financial cost of providing abortions and have thus resulted in clinic closures, exacerbating accessibility problems in many regions. The lack of abortion providers complicates the requirement that a physician perform an abortion, especially in rural areas where the nearest abortion clinic is several hours away. This problem is further compounded in states that require an in-person consultation with a physician and waiting before obtaining an abortion.

To address this problem, Planned Parenthood of the Heartland (PPH) began providing medical abortions in 2008 in rural communities via "telemedicine."[2] At the time, PPH had 17 clinics in Iowa, only three of which had an on-sight physician. Some of the physicians occasionally traveled to three other clinics, but the remaining 11 clinics did not provide abortion care (Thomson-DeVeaux 2013). As a result, women in some parts of the state needed to make 500-mile round trips to obtain an abortion.

[2]Anti-abortion rights activists often refer to this procedure as "robo-abortion," "webcam abortion," and "skype abortion."

Table 5.1: Key Events in the Iowa Telemedicine Debate

Date	Event
7/1/08	Planned Parenthood of the Heartland (PPH) begins telemedicine program in Iowa.
6/24/10	Complaint filed by Operation Rescue
1/13/11	Board dismisses complaint
1/18/11	SF 41 introduced by Senators Johnson; bill would require physicians physical presence to induce abortion.
2/2/11	HF 192 introduced by Representative Windschitl; identical wording as SF 41.
6/24/11	Iowa Right to Life announces it has collected 20,000 signatures on a "Stop Webcam Abortions" petition to the Board of Health
6/25/11	Group of 14 doctors, nurses, and other health care professionals file petition with Board of Health
6/28/11	Iowa Board of Medicine (IBM) votes to accept the petitions, begins review of telemedicine.
6/18/13	IBM announces a Notice of Intended Action regarding proposed rule that would require the physician presence of a physician.
8/28/13	The IBM holds a Public Hearing regarding the proposed rule.
9/3/13	The IBM adopts the proposed rule.
9/30/13	Planned Parenthood of the Heartland (PPH) files a lawsuit in Polk County to block implementation of the rule.
11/5/13	Polk County District Judge Karen Romano grants a temporary stay, allowing telemedicine abortions to continue.
11/6/13	The proposed rule was scheduled to go into effect before Judge Romano granted the stay.
1/29/14	HF 2175 introduced by Representative Windschitl; bill prohibits the use of telecommunications technology to distribute medicine causing an abortion.
2/11/14	HF 2175 passed the House.
2/12/14	HF 2175 introduced in the Senate, died in committee after failing to be scheduled for a floor vote by a legislative deadline.
8/18/14	Polk County Judge Jeffrey issued a ruling in favor of IBM, stating that the adopted rules would go into effect in 30 days.
9/16/14	Iowa Supreme Court issues temporary stay allowing telemedicine abortions to continue.
9/18/14	Rule prohibiting telemedicine abortion scheduled to go into effect before the Iowa Supreme Court issued a stay.
3/11/15	Oral arguments heard in the Iowa Supreme Court.

5.4.1 Abortion and the Practice of Telemedicine

According to the American Telemedicine Association, telemedicine is the delivery of health care services using telecommunications technology, such as videoconferencing, remote monitoring of vital signs, transmission of still images, surgeries using robotic instruments, and nursing call centers. The practice is both widespread longstanding. For example, since the 1920s, radios have been used to provide med-

ical advice to clinics on remote ships. Today, telemedicine is embraced by federal programs, such as the U.S. Department for Veteran's Affairs, Medicaid, and the Affordable Care Act, to reduce costs, increase quality, and improve access to health care (Boonstra 2013, Semuels 2014). In Iowa, telemedicine is regularly used for psychiatry, radiology, stroke and burn treatments, heart disease, cancer, diabetes maintenance and other geriatric issues.

A woman seeking a medical abortion via telemedicine follows a similar procedure as a patient seeking face-to-face treatment. She has an ultrasound performed by a trained technician, receives and signs informed consent about the procedure, and undergoes counseling about the decision to have an abortion. At this point, the physician reviews the woman's medical history and ultrasound images with the patient via teleconference, determines eligibility for a medical abortion, answers patient questions, and finally, remotely releases a locked drawer. The physician watches as the patient takes the first pill (mifepristone) and is sent home to take additional medication (misoprostol) to induce a miscarriage.[3] Since the program started in 2008, PPH has performed more than 7,000 telemedicine-assisted abortions.

Several peer-reviewed studies have evaluated the use of telemedicine abortion. The overwhelming consensus is that telemedicine abortion is safe, and increases patient satisfaction among rural patients. None of the peer reviewed research finds a statistically greater incidence of negative effects of medical abortion or patient satisfaction between face-to-face and telemedicine patients (Grossman et al 2011; Grindlay et al 2013). During the time period in which telemedicine abortion was legal, the incidence of abortion in Iowa decreased, though the proportion of non-surgical abortions

[3]Many critics of telemedicine abortion specifically mention the supposed danger of women inducing an abortion with misoprostol unsupervised and at home. For this reason, it is important to note that patients receiving face-to-face treatment also take the misoprostol at home.

and early-gestational abortions increased (Grindlay et al 2013).

5.4.2 The Political Debate around Telemedicine at the Iowa Board of Medicine

Telemedicine abortions entered the agenda of the Iowa Board of Medicine (IBM) in 2010 when the anti-abortion rights group Operation Rescue filed a complaint that the procedure violated the state law requiring that only a physician can perform an abortion. In particular, the complaint lists five "major areas of concern": 1) violation of law requiring only licensed physicians perform abortions; 2) the administering of medication does not follow FDA protocol; 3) PPH willfully engages in criminal negligence and violates consumer protection law by not following medication protocol; 4) overbilling of insurance companies; and 5) "patient abandonment" because the physician interacts with the patient only once (Operation Rescue 2010). The complaint asked the Board to use their administrative powers to cease the practice immediately, and called for disciplinary action against PPH physician Dr. Susan C. Haskell and Thomas William Ross specifically. The IBM, mostly appointed by Democratic Governor Chet Culver, established an ad-hoc committee in August 2010 to study telemedicine issues.

The issue became a significant point of debate during the 2010 gubernatorial election between Culver and former Republican governor Terry Branstad. Speaking about telemedicine abortion in an October 2010 interview, Branstad stated, "I think it should be discontinued. Legally, I'm not sure what role the governor has in that. But I certainly don't think that's appropriate" (Boshart 2010). In response, Culver argued:

> "What Terry Branstad is proposing is to shut down all telemedicine. You can't just very narrowly pick and choose who is allowed to use telemedicine. This shouldn't be about ideology. This should be about health care and providing services, including family-planning services. He's over-simplifying a very complex issue" (Boshart 2010).

The committee conducted a lengthy investigation into telemedicine and dismissed the complaint on January 13th, 2011. As is customary for the Board, they declined to provide an explanation for their decision. In a letter to Cheryl Sullenger[4] from Operation Rescue who filed the complaint, the Board wrote:

> "After a thorough investigation and careful review of the investigative materials obtained in this matter, the Board voted to close the file without taking disciplinary action against Dr. Haskell. Although this may not be the outcome you were seeking, you can be assured that your complaint was investigated and the Board reached its decision after full review of the investigative record." (Bowden 2011).

Republicans gained the majority in the Iowa House of Representatives and narrowed the Democratic majority in the State Senate in 2010. Republicans in both chambers introduced bills that stated, "A physician shall only diagnose and prescribe a medically induced abortion in person, and shall not utilize other means, such as an internet web camera, to do so" (SF41 and FH192).[5] Neither bill reached the floor for a vote, and telemedicine abortions in Iowa continued.

Branstad won the gubernatorial election and steadily began to shape the 10-member Board of Medicine, which generally includes seven physicians and three members of the public. Several of his nominees garnered high pro-file debate within the state, including Colleen Pasnik, the former Director of the Family Life Office for the Archdiocese of Dubuque and past employee of Dubuque County Right to Life. Democrats blocked Pasnik's appointment because she was photographed with Operation Rescue activist Sullenger at the 2010 Board meeting debating telemedicine

[4]Sullenger, a national activist, is well known because of her conviction of bombing San Diego's Alvarado Medical Clinic in 1987.

[5]SF41, introduced on 1/18/11, sponsored by Senators David Johnson (R-3), Kent Sorenson R-37), Randy Feenstra (R-2), Bill Anderson (R-3), Brad Zaun (R-20), Nancy Boettger (R-9), James Seymour (R-28), and Jerry Behn (R-24). HF192, introduced 2/2/11, sponsored by Matt Windschitl (R-17) and Dwayne Alons (R-4).

abortions. By 2013 the IBM was entirely composed of Branstad appointees,[6] including Monsignor Frank Bognanno, the pastor at Des Moines' Christ the King Catholic Church. According to IBM meeting minutes from 2010, Bognanno "presented a letter that requested the board to uphold the fundamental value of human life from the moment of conception to the moment of natural death" (Leys 2012). Another Branstad IBM appointee was Greg Hoversten, a former state representative who had previously introduced a bill in 2001 that would mandate a 24-hour waiting period and include adoption language in informed consent (Radio Iowa 2001).

The Iowa Right to Life continued to mobilize Iowans on the issue of telemedicine abortion, and in June 2013 the group announced they had collected 20,000 signatures on a "Stop Webcam Abortions" petition. The petition asked the Board to "make adjustments in their guidance and rules to end webcam abortions in Iowa" (Boshart 2013, Wiser 2013). A collective of 14 medical professionals submitted a second petition that raised questions about the safety of telemedicine abortions. Kelly Larson, a nurse at a Crisis Pregnancy Center, was one of the 14 health professionals who signed the petition. According to Larson, "I believe that this proposed rule is a necessity due to the risks that are imposed to the women if any side-effects were to happen" (Henderson 2013).

Daniel McConchie, Vice President of Government Affairs for Americans United for Life, was one of only three members of the public permitted to address the IBM before they made a decision regarding when they should vote on accepting the petition. In pressing for an immediate vote, McConchie stressed that the IBM must address the issue with urgency because Iowa was becoming "ground zero" for "webcam abortions" (Wiser 2013). Jill June, CEO of Planned Parenthood of the Heartland, "There were a lot of things that were really very unusual, and that's why you didn't see the

[6]IBM members serve 3-year terms and Branstad became governor in 2011.

kind of local involvement or comments at that meeting. People simply weren't aware of what was taking place" (Marty 2013). The Board voted on June 28th, 2012, 8-2 to accept the petition just days after the petition was filed, against objections from the Board's legal director, the Iowa Attorney General's office and two dissenting members of the Board. The objecting parties claimed there should be a thorough investigation into the issue before rushing forward with the process (Noble 2013, Wiser 2013).

The proposed rule sought a new standard for the practice of medical abortions that would require: 1) a physician perform an in-person physical exam of the patient to determine gestational age and intrauterine location of the pregnancy; 2) physical presence of a physician a the time an abortion-inducing drug is provided; 3) the physician inducing the abortion schedule a follow-up visit with the patient at the same facility 12-18 days post medical abortion; and 4) parental notification if the patient is a minor. Some aspects of the rule did not constitute significant changes, such as requiring a follow-up visit. However, the requirements of a physical presence of a physician and that the follow-up visit be at the same location were substantially different.

When the Board considered a petition about telemedicine abortion in 2010, the primary concern was whether or not Planned Parenthood of the Heartland was in violation of a state law requiring that a physician conduct an abortion. In particular, opponents of telemedicine abortion contended that because only a nurse practitioner (and not a physician) was *physically present* when the medication was administered, the program violated a law that mandated only a licensed physician could perform an abortion. In the debate over telemedicine three years later, the central question focused on the *safety* of telemedicine abortion rather than *compliance* with existing law. Proponents of the petitions to change the rule contended that the system was dangerous because physicians had little direct oversight and the women can suffer complications at home, and that potentially undertrained staff practiced medicine.

Opponents of the rule change argued that the motivation was not patient safety but was political in nature. They argued that this was a blatant attempt to restrict access to abortion in rural areas. Additionally, they believed that concerns about patient safety were disingenuous because the IBM was not restricting telemedicine in other areas of medicine, including psychiatric care that administered medication with potentially dangerous side effects. They argued that the Board did not address the fact that women obtaining a medical abortion with a physician physically present also take the misoprostol and undergo the induced abortion in their own home. Furthermore, they argued that requiring women to drive long distances while undergoing a medically induced miscarriage was more dangerous.

The Board issued a Notice of Intended Action for a proposed rule amendment on June 28th, 2013, and allowed written comments to be submitted until a public hearing on August 28th, 2013. The proposed rule stated, "when inducing an abortion by providing an abortion-inducing drug, a physician must be physically present with the woman at the time the abortion-inducing drug is provided" (Medicine Board [653] Notice of Intended Action). The Legislature's Administrative Rules Review Committee heard arguments on August 6th to delay the Board's proposed rule process for 70 days, but the motion died on a 4-4, party-line vote that failed to exceed the necessary 2/3 support needed to pass (Leys 2013). At the public hearing, 28 people testified, and written comments from 244 individuals and organizations were submitted. The Iowa Board of Medicine adopted and filed the proposed rule on September 3rd, 2013, and was scheduled to go into effect on November 6th, 2013.

5.4.3 The Ensuing Court Battle over the IBM Rule

Planned Parenthood of the Heartland (PPH) filed a lawsuit in Polk County District Court on September 30th, 2013, asking the judge the block the rule from being implemented. Specifically, the lawsuit made several claims, including: the rulemaking

process was rushed; that the IBM did not consider factual evidence regarding the safety of the process; that the IBM included activists such as Monsignor Bognanno who had previously testified against abortion generally and telemedicine abortion specifically; and that eliminating telemedicine abortion would violate due process and equal protection clauses of the Iowa and U.S. Constitutions because it would reduce access to legal abortion for certain groups of women.

Just days before the new rule was set to go into effect, Polk County District Judge Karen Romano granted PPH's request for a temporary stay on November 5th, 2013, pending the Court final ruling. In the stay order, Judge Romano commented on the "peculiarity" of the Board to regulate the telemedicine practice of only abortion and questioned the safety concerns of the Board (*Planned Parenthood of the Heartland, Inc., v. Iowa Board of Medicine* (2013) CVCV046429 Ruling on Motion to Stay Pending Judicial Review).

A final decision from Polk County District Judge Jeffrey Farrell ruled in favor of the Iowa Board of Medicine on August 18th, 2014, which allowed the rule to go into effect absent a stay granted by the Iowa Supreme Court. In the decision, Judge Farrell first affirmed that the IBM has the authority to establish standards of practice for the medical profession. He also noted that the IBM followed legal requirements for making new rules, including holding public hearings, allowing for oral and written comments, and the minimum time between proposal and adoption. However, he also noted that the IBM's move "invited scrutiny." The Board moved quickly and against legal counsel, held only the minimum number of meetings, and refused requests from groups like the Iowa Medical Society (IMS) and Iowa Osteopathic Medical Association (IOMA) to take additional time to engage in more discussion.

In the decision, Judge Farrell responded to each of PPH's claims. He determined that the Board was in full compliance of all statutes regarding the rulemaking process and allowed for comments from proponents and opponents of the proposed

rule. The IBM favored the evidence from the anti-telemedicine abortion groups over evidence provided by PPH and its allies; however, this is the role of the Board. According to Farrell:

> "It is not for the court to review medical studies and determine which is the most persuasive. If it did so, it would be substituting its judgment for that of the board of medicine. The only question for the court is whether the board considered the information submitted by PPH and other opponents of the rule. The board clearly considered the information provided by PPH, but disagreed with PPH's opinions." (*Planned Parenthood of the Heartland, Inc., v. Iowa Board of Medicine* (2013) CVCV046429, 22)

Judge Farrell responded to claims from PPH that the rule violated the due process and equal protection clauses of the Iowa and US Constitution. He acknowledged that the implementation of the rule would result in longer travel times and additional costs for some women. For example, a woman traveling from Red Oak, IA under the new rule would need to drive four hours to Des Moines round trip for the procedure and again for a follow up appointment. He cited the case of *Planned Parenthood of Greater Texas v. Abbott* (2014), stated that waiting periods and longer travel distances did not constitute an undue burden under *Casey*. Therefore, eliminating telemedicine abortions may pose a burden for some women, but not an *undue* burden.

PPH appealed to the Iowa Supreme Court and a last-minute stay was granted on September 16, 2014, just two days before the rule was scheduled to go into effect. Supporting PPH's case are groups like the American College of Obstetricians and Gynecologists (ACOG). In their Friend of the Court brief, the ACOG argued that the rule will make safe and effective first trimester abortions inaccessible to hundreds of thousands of women, that the IBM's "purported reasons underlying them, bear no rational relationship to any legitimate public health objective," and that the rule will interfere with the physician-patient relationship (American College of

Obstetricians and Gynecologists 2013). The Iowa Commission against Domestic Violence further argued that the rule would decrease abortion access among Iowa's most vulnerable women, including "rural women, women with pre-existing medical conditions, women experiencing intimate partner violence, sexual assault survivors, and low-income women" (Iowa Coalition Against Domestic Violence et al 2013). The Iowa Supreme Court heard oral arguments in *Planned Parenthood of the Heartland Inc. and Dr. Jill Meadows v. Iowa Board of Medicine* on March 11, 2015 and a ruling has not yet been issued.

5.4.4 Telemedicine Abortions in the Iowa Today

Some state legislators have recently raised the issue of telemedicine abortion in the statehouse. Representative Windschitl, a sponsor of earlier efforts to enact a statutory ban on telemedicine, introduced a bill on January 29th, 2014, that would ban telemedicine abortion. HF 2175 mandated that, "A person shall not cause to be dispensed to a pregnant woman via telecommunications technology, including but not limited to a webcam or teleconferencing, any chemical agent or drug designed to terminate a human pregnancy with the intent that the pregnant woman will use the chemical agent or drug to terminate the woman's pregnancy." The bill passed the House on February 11th, 2014, on a mostly party line vote of 55-42. The bill was read in the Democrat-controlled Senate on February 12th, 2014 and died in committee after failing to be scheduled for a floor vote by the legislative deadline.

5.5 Taxpayer Funded Insurance in the State of Georgia

Abortion was a major legislative issue in 2012, when there were two high profile bills under consideration: gestational bans on abortion after 20 weeks and restrictions on state-funded insurance coverage of abortion. While the gestational ban found fairly quick success in the legislature, the insurance ban faced repeated

failures in the legislature before finding success in the bureaucracy.

Table 5.2: Key Events in the Georgia Abortion Insurance Coverage Debate

Date	Event
2/8/12	HB 954 introduced by Representative McKillip; contends that a fetus can feel pain at 20 weeks and bans abortions at 20 weeks.
2/15/12	SB 438 introduced by Senator Crane; would prohibit state employee insurance coverage if abortion with no exceptions; amendments are offered to add exceptions; bill dies in the Insurance committee.
2/21/12	HB 1116 introduced by Representative Neal; would prohibit vasectomies unless the life of the man was at stake; bill dies in Health and Human Services committee
3/7/12	SB 438 passes Senate; First Walk Out of Democratic Women from Senate chamber in protest.
3/29/12	SB 438 introduced in House; dies in Insurance committee
3/29/12	Fetal Pain bill HB 954 passes House and is introduced in the Senate
5/1/12	Final day of session; Second Walk Out; Fetal Pain HB 954 passed both chambers and is signed
2/1/13	SB 98 introduced by Senator Hill; would prohibit the coverage of abortion by an insurance program offered through a state or federal law or regulation.
2/7/13	HB 246 introduced by Representative Golick; would allow the Georgia World Congress Center Authority to select its own insurance plan.
2/13/13	SB 164 introduced by Representative Crane; would prohibit the coverage of abortion by any insurance plan administered in the state; dies in Insurance committee
2/19/13	HB 246 passed House.
3/7/13	Insurance bill SB 427 introduced by Senator Orrock; would require that insurance companies cover abortion when the pregnancy is the result of rape or incest; dies in Insurance committee
3/25/13	HB 246 amended several times to add a ban on abortion coverage; passes Senate, but is blocked by Speaker Ralston in House
8/8/13	The Community Health Board selects a new insurance company for state employees and amends benefits coverage to exclude abortion.
1/1/14	The new state employee insurance plan goes into effect
2/24/14	HB 1066 introduced by Representative Taylor; would prohibit the state employee insurance plan from covering abortion; dies in Insurance committee
3/3/14	SB 98 (first introduced in February 2013) passes the Senate with amendment.
3/18/14	SB 98 amended in House with amendment, and passes Senate as amended.
3/18/14	HB 246 passes House without the abortion amendment.
3/20/14	HB 246 passes Senate without the abortion amendment.
3/21/14	SB 98 signed by governor
4/21/14	HB246 by governor

5.5.1 Contentious Year for Abortion Policy in the Legislature

Tension over the issue of abortion reached a peak in 2012, with sincere and symbolic bills seeking to restrict access to various components of reproductive health. Representative Doug McKillip (R-115) introduced HB 954 on February 8th, 2012, mirroring an unsuccessful bill introduced in 2011 (HB 89). The bill, formally titled the "Pain Capable Unborn Child Protection Act" and informally referred to as the "Fetal Pain Bill," asserted that fetuses could feel pain, that abortions performed after the first trimester must be performed in an ambulatory surgical center, and banned abortions after 20 weeks gestation. Other Republicans in the chamber added exceptions to the bill that allowed for abortions when the pregnancy was "medically futile,"[7] when the woman's life was at stake, or when the pregnant woman faced serious irreversible physical impairment. The bill garnered national attention as the "Women as Livestock Bill" when Republican Representative Terry England (R-116) drew analogies of women carrying medically futile pregnancies to livestock on his farm. He argued that if farmers "deliver calves, dead or alive" then a woman carrying a dead fetus should also carry it to term (Barbato 2012).

The following week Senator Mike Crane (R-28) introduced a second bill (SB 438) on February 15th, 2012, that prohibited the health insurance coverage of abortion for approximately 670,000 state employees and their dependents. Other members of the chamber added amendments against the wishes of Crane that allowed for exceptions for death or irreversible serious physical impairment of the woman. In opposing an exception for medically futile pregnancies, Crane said it was best to "Let life take its course. If the baby survives, it survives" (Campbell 2012b).

Crane argued that the bill did not ban abortions. He urged colleagues to support the legislation as a way to save taxpayer money and to take a stance against

[7]The bill includes a definition of medically futile pregnancies. The term means Profound and "irremediable" anomalies "incompatible with sustaining life after birth."

abortion (Monty 3/8/12). Thus, the debate around the bill became less about insurance coverage than the typical abortion politics rhetoric of "personal choice" and "protecting life." Crane summarized his perception of the debate by saying, "for the most part they talked about what they saw as a women's right to choose. Never once did they mention the baby" (CBN News 2012).

Democratic women claimed these bills were part of a broader "war on women." On February 21st, 2012, Representative Yasmin Neal (D-74) introduced a "parity" bill (HB 1116) with five other women that prohibited the performance of vasectomies. The bill states that "thousands of children are deprived of birth in this state every year because of the lack of state regulation of vasectomies." Using much of the same language contained in the abortion-related bills, she sought to draw attention to the stringency of abortion restrictions introduced by her colleagues (language identical to other bills introduced in the Georgia House in 2012 is italicized):

> "In determining whether a vasectomy is necessary, no regard shall be made to the desire of a man to father children, to his economic situation, to his age, to the number of children he is currently responsible for, or to any danger to his wife or partner in the event a child is conceived. A vasectomy may only be performed to *avert the death of the* man *or avert serious risk of substantial and irreversible physical impairment of a major bodily function. No such condition shall be deemed to exist if it is based on a diagnosis or claim of a mental or emotional condition of the* man."

The bill had little substantive effect in the legislative process, but raised local and national media attention on the restrictive abortion policies under consideration in the chamber. The bill died in committee. Frustration among Democrats and women continued to escalate, leading Democratic women to walk out of the senate chamber under protest on March 7th 2012.

The ban on abortions after 20 weeks gestation (the "Fetal Pain" bill) passed both Republican-controlled chambers on March 29th, the final day of the session. The governor signed it on May 1st, 2012, amidst significant tension. Many of the

lobbying groups involved with the bills were present for the vote. Tension spilled into the hallways where a state trooper stopped a physical altercation between the Georgia Right to Life President Dan Becker and the Perinatal Infertility Coalition of Georgia Executive Director John Walraven (Sheinin et al, 2012). Democratic women and their supporters walked out of the Senate again in protest. Wearing yellow police tape, the women and some supporters held hands and marched into the hallways yelling "we will remember!" (Atlanta Journal Constitution 2012). As the vote passed, Democrats turned their backs on Representative McKillip, the sponsor of the bill.

The insurance bill passed in the Senate on March 7th, 2012, though it faced stiffer opposition than during its debate in the House. In particular, legislators expressed concerns about the lack of rape or incest exceptions and language in the bill regarding early abortions for medical emergencies, such as tubal pregnancies. Anti-abortion news sources blamed House Speaker David Ralston (R-7) for blocking the bill from exiting the Insurance Committee, alleging that he claimed he would only allow one abortion bill per session and supported the "Fetal Pain" bill over the insurance ban (Darnell 2012).

Despite this blockage in the House, legislation to ban insurance coverage of abortion continued moving forward in the Senate in the next year. Senator Judson Hill (R-32) introduced SB 98 on February 1st, 2013, that mandated, "No abortion coverage shall be provided by a qualified health plan offered through a state or federal law or regulation within the State of Georgia." The new bill included an exception for when the pregnant woman faced death or irreversible physical impairment of a major bodily function. Hill emphasized that women under state insurance coverage would still be legally able to get an abortion under the bill, but that "making someone pay for another's abortion, whether one or many" would not occur (Gillooly 2/7/13). The bill, which enjoyed Senate leadership support, faced strong opposition from Democratic Senators. After getting referred to the Insurance Committee, the bill remained

dormant for more than a year.

Several other senators offered different bills to regulate abortion insurance coverage. Senator Crane introduced a bill (SB 164) on February 13th, 2013, that defined abortion and said that "No health insurance plan shall offer coverage for abortion services." Georgia Right to Life (GRTL) strongly supported the bill, contending that "no abortion should be paid for by taxpayer dollars" (Richards 2013). The bill died in the Insurance and Labor committee. Senator Nan Orrock (D-36) introduced a bill (SB 427) on March 7th that would "provide that certain qualified health plans that do not provide abortion coverage shall offer supplemental optional coverage for abortion services if the pregnancy is a result of rape or incest." This bill also died in committee. Around the same time, Representative Rich Golick (R-40) introduced a bill that granted the Georgia World Congress Center authority to provide an insurance program and retirement plan of its choosing (HB 246). The bill initially had no mention of abortion and passed the House on February 19th, 2013. Several senators offered a flurry of "ambush amendments" (Henry 3/25/13) that added language to prohibit abortion except when necessary to preserve the pregnant woman's life.[8]

The amended version of the bill passed in the Senate on March 25th, 2013, on a party line, but the amended version of the bill languished in the House. According to Republican House Speaker Ralston, the "hastily crafted" legislation would have also banned necessary procedures, such as those performed after a miscarriage (Atlanta Journal Constitution 2013). He said he would support efforts to enact a similar bill in

[8]Senator Crane offered an amendment that included Senator the same language from his bill SB 164: "No health insurance plan shall offer coverage for abortion services." Senator Renee Unterman(R-45) amended to allow for an exception for when the abortion was "needed due to the mother's medical necessity or to preserve mother's life." Senator Nan Orrock offered several failed amendments that reflected the substance of her amendment to SB 164, to provide additional exceptions for when the pregnancy resulted from rape or incest. Senator Hill provided an amendment that would ban abortion coverage from all insurance plans, but it was ruled non-germane.

the next session provided they included exceptions for medically necessary abortions.

5.5.2 Policymakers Consider a New Strategy

After repeated failed attempts to pass an insurance bill, many of the key actors engaged in a public discussion about developing a new strategy. In addition to the regular legislative process, some speculated that the governor could enact the bill administratively by directing the relevant bureaucratic agencies to modify the insurance coverage of state employees. Senator Crane, the sponsor of SB 164 and the amendment to HB 246, said:

> "Because of the way the State Health Benefit Plan is run, the companies that operate the plan are directed by the state on what to offer in the plan. ... This is just one more coverage that they can specify through their plan." (Campbell 2013)

The governor hinted that future action would be pending when he said that, "Over the recess period we can look at ... what our state health benefit plan provides and whether or not there are other ways short of legislation that this subject can be addressed" (Galloway 2013). Georgia Right to Life also supported an extra-legislative approach to policymaking. Mike Griffin of GRTL said,

> "Governor Deal has offered an executive solution, by using his regulatory powers, to assure that taxpayer funds will not be used for elective abortions. We hope that he'll be able to work with the Department of Community Health and be able to apply an executive solution where a legislative solution is not going to be found." (Galloway 2013).

5.5.3 The Georgia Community Board of Health Policy Adoption

A nine-person Community Health Board (CHB), appointed by the governor and confirmed by the state Senate, governs the Georgia Department of Community Health (DCH). The DCH is responsible for overseeing various programs such as the State Health Benefit Plan (SHBP), Healthcare Facility Regulation and Health

Information Technology in Georgia. Nearly a quarter of Georgians receive health cares services through agencies overseen by the DCH. The State Health Benefit Plan (SHBP), used by about 670,000 Georgia state employees and their dependents, had until bureaucratic action covered abortions as it had covered other outpatient elective surgeries.

Republican Governor Nathan Deal, a strong opponent of legal abortion, ran for reelection in 2013. Deal supported the previous efforts in the state legislature to eliminate abortion coverage from state funded health insurance plans, and he pushed the Community Health Board to revise the rules to prohibit it in the summer leading up to the election (Jones 2014b, Atlanta Journal Constitution 2013). In a regularly scheduled meeting, the CHB voted on a new state health plan. United Healthcare had insured the existing plan, but their contract was set to expire. On August 8th, 2013, the CHB approved a "significant realignment" of the health plan (Miller 2013). The CHB awarded two major contracts to Blue Cross and Blue Shield of Georgia.[9] The change in insurance providers led to a change in benefits coverage. The new benefit plan reduced premiums for many state employees, but it eliminated coverage of abortion unless the pregnant woman's life was in jeopardy.

The CHB vote (5-3, 1 abstention) was contentious. One board member raised concerns that residents in some parts of the state had a choice of insurers but in other parts did not. There was no discussion about the abortion restriction and the change in abortion coverage is not listed in the meeting minutes' summary of the SHBP resolution. While 18 other states do restrict abortion coverage in state health insurance plans, the lack of exceptions for when the pregnancy is the result of rape or

[9]United Healthcare issued a statement protesting the lost contract: " In what has to be one of the most egregious examples of a state entity acting outside the boundaries of Georgia procurement law, the Department of Community Health ... is conducting a secret, hidden procurement for one or more 2014 health insurance plan" (Miller 2013).

incest, where the woman's health is impaired, or when there is a severe fetal anomaly makes it one of the most conservative bans in the country (Shapiro 2013). The policy is also more conservative than the federal guidelines, which include exceptions for rape and incest.

Those who sought to make the change in abortion coverage in the legislature, including Senator Crane and the Georgia Right to Life,[10] applauded the change in benefits. Governor Dean issued a statement of support:

> "Today's vote by the Department of Community Health board shows our state's commitment to reducing the number of abortions in our state by ensuring that state taxpayers aren't paying for a procedure that many find morally objectionable." (Atlanta Journal Constitution 2013)

For others, the board's action at the behest of the Governor was controversial. For example, Democratic Representative Pat Gardner said, "I'm a big fan of this governor ... I don't agree with him on all the issues, but he has been very deliberate and very thoughtful. And this just smacks of electioneering. And that's disappointing to me" (Associated Press 2013).

The newly approved SHBP went into effect January 1st, 2014. The change in policy passed in a resolution selecting a new insurance policy and was not an official rule or regulation. As a result, there was no need for the Board to go through the public commenting procedure usually required before new rules are adopted. However, because the policy change was not an official board rule, it was vulnerable to change in the future by the legislature or Board.

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[10]Senator Crane said, "We have protected the life of a fish. I expect the same for the life of the unborn" (Darnell 2013). Suzanne Ward, spokeswoman for Georgia Right to Life said, "The majority of Georgians do not support their tax dollars for abortion on demand and this direction reflects their will. Why would Georgians want to pay for what is truly not health care, but the destruction of human life?" (Atlanta Journal Constitution 2013)

5.5.4 Codifying the Insurance Ban in the Legislature

Less than two months after the new SHBP went into effect, the legislature began work on codifying the insurance coverage ban on abortion. Representative Darlene Taylor (R-173) introduced a bill (HB 1066) on February 24th, 2014, that mandated, "The health insurance plan [SHBP] shall not include ... expenses for elective abortion services unless needed due to a physical medical necessity and to preserve the mother's life." At an Insurance committee hearing on the bill two days after the bill was introduced, Taylor explained that the bill was drafted at the request of Governor Deal, who had recently been reelected as governor (Jones 2014b). She emphasized that the bill did not make any further changes to public insurance coverage of abortion. When questioned by her colleagues on why the bill was necessary, she argued that it was needed to make sure the policy currently in place matched state law regarding abortion. According to Taylor, "Some people have said this is an abortion bill. It is not an abortion bill. It is an insurance bill" (Jones 2014b).

The committee hearing was poorly attended and had few witnesses, and Insurance Committee Chairman Richard Smith (and bill cosponsor) acknowledged the meeting was scheduled on short notice (Jones, 2014b). A lobbyist at the meeting representing the Georgia Reproductive Endocrinologists proposed allowing coverage of abortions due to rape or incest. The Catholic Archdiocese of Atlanta and Representative Taylor strongly opposed adding these exceptions. No subcommittee meeting was held on the bill with an opportunity for public comment or expert testimony. The full committee never voted on the amendments or bill, and it died in committee at the end of the session.

Senator Hill's bill SB 98, first introduced in February 2013, got a second life a year later when the Insurance committee favorably reported on and discharged a new version of the bill. Now based on model legislation from the Americans United for

Life, the bill maintained some of the original text but now also explicitly prohibited abortion coverage under the federal Patient Protection and Affordable Care Act, with the only exception being in the case of "medical emergency." The bill passed in the Senate on March 3, 2014. The House Insurance Committee added additional language so that the bill would achieve two purposes: prohibit abortion coverage through the health care exchanges created by the PPACA, and ratify the CHB's decision to eliminate abortion coverage in the SHBP.

According to House Insurance Committee Chairman Smith, SB 98 "provides permanency rather than the temporary nature of rules and reg[ulation]s" (Torres 2014). Minority House Whip Carolyn Hugley (D-136) spoke out against the bill for not allowing exceptions in the case of rape or incest and criticized the House Insurance Committee proceedings. Similar to the hearing for HB 1066, the bill had no subcommittee hearing, the public was not allowed an opportunity to testify, and the committee approved the bill in less then 15 minutes (Torres 2014). The bill passed both chambers on March 18th, 2014, and Governor Deal signed the bill on March 21st, 2014. Several abortion interest groups involved in lobbying on behalf of the bill celebrated the passage of SB 98. Genevieve Wilson of GRTL praised Governor Deal's leadership when she said, "As a pro-life woman and mother, I am deeply grateful Governor deal signed this law" (Andersen 2014). Charmaine Yoest, President of AUL, upon whose model legislation the revised SB 89 was based, thanked the Georgia Catholic Conference and the Archdiocese of Atlanta for their lobbying efforts (Andersen 2014, AUL Press Release 2014).

Receiving far less fanfare than the passage of SB 98, HB 246 remerged on the legislative stage. This bill initially granted the Georgia World Congress Center authority to select its own insurance plan, but was later amended to ban abortion coverage. The amendments prohibiting abortion coverage for employees of the Georgia World Congress Center were removed from the bill and the bill went back to its

original form. It passed the House on March 18th and Senate on March 20th, and the governor signed it into law a week later.

5.5.5 Public Health Insurance Coverage of Abortion in Georgia Today

State legislators tried unsuccessfully to prohibit state-funded insurance plans from covering abortion in at least three different pieces of legislation in the two years leading up the Community Health Board's adoption of a new health plan. Each time, the bill failed to make it out of committee or did not get enough votes to pass on the floor. The CHB enacted the change in the state health insurance program to end coverage of abortion at the direction of the governor without opportunity for public comment or legislators' input. After the policy was already in placed, it was codified relatively easily in the legislature. The bill's sponsors and supporters downplayed the impact the bill would have on future abortion access. As Representative Darlene Taylor explained, "It does not change the current plan. This is a clarifying bill" (Jones 2014a). After the CHB took action, two public health insurance bills passed after years in which no similar bills found success.

5.6 Targeted Regulation of Abortion Providers (TRAP) in Virginia

For nearly a decade, the Virginia House of Delegates pushed for legislation that would impose additional regulation on clinics that perform abortions. Strategic legislative maneuvering in 2012 got such a bill on the floor for a Senate vote. This maneuvering was part of an ongoing battle between the legislature, the Virginia Board of Health and Commissioners, two Attorneys General, two Governors and the interest groups that played a supporting role in keeping the process moving. The bill that ultimately passed (but is facing a possible reversal) classifies all outpatient clinics that perform at least five abortion clinics as a hospital. Hospitals are required to follow strict architectural requirements that are too cost prohibitive for most clinics

to adopt. While the saga over this abortion regulation continued, the state also considered several other bills that received national attention, including bills that would determine that "personhood" began at the moment of conception, and an informed consent bill that initially required transvaginal ultrasounds.

5.6.1 Decades of Legislative Attempts to No Success

The Board of Health did not regulate abortion clinics in the state of Virginia until 2011. Clinics were classified as "physician's offices" instead of hospitals, and thus not under their purview of regulation. As such, they did not need to be in compliance with the strict standards required of surgical centers (Ertelt 2011). Instead, the Board of Medicine licensed practitioners. Republicans introduced bills that would change the licensing and regulation of abortion clinics or treat them as ambulatory surgical centers annually since at least 2002, including a bill sponsored by Republican Attorney General Ken Cuccinelli when he was a state senator (Kumar 2010). These bills had strong support from anti-abortion rights interest groups in the state like the Family Foundation of Virginian and were popular among Virginia Republicans. These regulatory proposals easily passed in the House but the Democrat-controlled Senate Committee on Education and Health always prevented the bill from reaching a floor vote.

In the fall of 2010, Cuccinelli responded to requests from Delegate Robert Marshall R-13) and Senator Ralph Smith (R-19), who asked if the state had the authority to regulate facilities that provide first-trimester abortions. (State law already required that second and third trimester abortions be conducted in a hospital.) In the opinion, Cuccinelli wrote, "It is my opinion that the Commonwealth has the authority to promulgate regulations for facilities in which first trimester abortions are performed as well as for providers of first trimester abortions, so long as the regulations adhere to constitutional limitations" (Cuccinelli 2010). In response, Smith

Table 5.3: Key Events in the Virginia Targeted Regulation for Abortion Provider

Date	Event
8/20/10	Attorney General Cuccinelli issues opinion that the Board of Health can regulate abortion clinics.
1/12/11	HB 1428 introduced by Delegate Marshall; would regulate clinics that performed 25 abortions a year.
1/12/11	SB 924 introduced by Senator McDougle; would direct Board to create regulations for hospitals (with no mention of abortion clinics).
1/26/11	HB 1428 passes House.
2/2/11	SB 924 passes the Senate in a unanimous vote.
2/7/11	SB 924 introduced into the House
2/17/11	HB 1428 introduced in Senate, referred to the Senate Education and Health Committee, dies in committee
2/21/11	SB 924 amended; clinics that performed five abortions a month must be classified as a hospital; bill passed in House as amended.
2/24/11	SB 924 returns to the Senate as amended; Senate votes on amended bill ends with a tie vote 20-20 that is decided by Lt. Gov. Bolling, who votes in favor.
3/26/11	SB 924 signed by governor.
8/29/11	Board published emergency regulations.
9/15/11	Board approves emergency regulations.
1/1/12	Emergency regulations go into effect.
6/15/12	Board proposed making emergency rules permanent with grandfather clause.
6/17/12	Cuccinelli issued statement that board exceeded authority and first memo to Commissioner Remley that said the rule wouldn't get certified with grandfather clause.
9/12/12	Cuccinelli issued second memo to Board about refusing legal counsel
9/14/12	Board votes to remove grandfather clause.
10/18/12	Remley resigns, citing inability to fulfill duties as a result of how rules were developed and enforced.
1/1/13	Governor McDonnell certified and posted rule, refers it back to the Board.
4/12/13	Board officially passes permanent resolution after commenting period.
6/1/13	Rules go into effect.
11/5/13	McAuliffe wins gubernatorial election
1/24/14	McAuliffe appoints Marissa Levin as the Interim Health Commissioner, then as the Health Commissioner.
5/12/14	McAuliffe orders review of rules, replaces 6 members of Board
6/1/14	Clinics are required to be in compliance with rule by this date; most clinics get temporary variances of exemption.
10/1/14	Levine announces her decision that the rules should be amended after commenting period.
12/4/12	Board begins a review process of the regulations.
1/12/15	A new public commenting period is open from 1/12/15-2/11/15.
2/13/15	Delegate Marshall introduced an amendment to a budget bill that would block the ability of the Board to conduct the review.
5/4/15	Attorney General Herring issues an opinion saying that regulations can only be imposed on new buildings and renovations.
6/4/15	The Board will meet to discuss proposed changes.

issued a statement that the opinion "sets the stage for future regulating of abortion clinics" and McDonnell wrote to Governor McDonnell to ask him to implement regulations per the opinion (Kumar 2010). At the time of Cuccinelli's opinion was released, the 15-member Board of Health had 11 board members appointed by the previous Democratic Governor Timothy Kaine and four vacancies, making changes to the regulations without a push from the legislature unlikely (Kumar 2010).[11]

On January 12th, 2011, Delegate Marshall introduced HB 1428. This bill would require the Board of Health to license clinics in which at least 25 first-trimester abortions were performed in a 12-month period along with hospitals, nursing homes and certified nursing facilities. The bill passed the House January 26th, 2011, on a 66-33 vote and was sent to the Senate.[12] The Senate Committee on Education and Health killed the bill on a 10-5 party-line vote on February 17th, 2011.

Republicans in the House were frustrated that their efforts to get a popular piece of legislation a "fair hearing" on the floor of the Senate were repeatedly stymied by this Committee. In the words of Republican Delegate Kathy Byron (R-22):

> "We have had a bill ... a safety bill 'that Delegate Richard Bell carried this year. And it went over into the Senate from the House and, like any bill that deals with anything remotely close to abortion, the bill died in committee. ... We haven't been able to get what I consider a fair vote because that committee is heavily weighted with people that all believe the same (thing)." (Terrini 2011a)

Realizing that no restrictive abortion policy would make it pass this Committee, Republicans found a way to strategically circumvent the Committee's gatekeeping.

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[11]McDonnell was elected in 2010 and Virginia Health Board members serve four-year terms.

[12]In the House of Delegates in 2011, 68 were Republican, 39 were Democratic and 2 were Independent). The Senate was comprised of 22 Democrats and 18 Republicans.

5.6.2 After Strategic Maneuvering in the Legislature, a Bill Passes

On February 2nd, 2011, Senator Ryan McDougle (R-4) introduced a bill (SB 924) that would amend a law that already required minimum standards for construction, maintenance, operations, staffing, equipping, staff qualifications and training at hospitals, nursing homes and certified nursing facilities. The bill added language that required the Virginia Board of Health promulgates and enforce minimum standards for "infection prevention, disaster preparedness, and facility security of hospitals, nursing homes, and certified nursing facilities." Because the bill did not mention abortion, it passed through the Committee on Education and Health, and passed the Senate with a unanimous vote on February 2nd, 2011. The House voted to add an amendment offered by Delegate Byron that essentially added the content of HB 1428, the bill she sponsored earlier that year. Specifically, the amendment stated that "facilities in which 5 or more first trimester abortions per month are performed shall be classified as a category of hospital." Delegate Byron explained that her bill was unrelated to the "pro-life vs. pro-choice debate" over abortion rights, and was intended to protect women's health. The House approved of the amendment with a 63-34 vote on February 21st, 2012, and the amended version of the bill passed 67-32 the same day.

By adding this language as an amendment to a Senate bill, the bill was not required to get past the gatekeeping Committee on Health and Education, which would have blocked the bill because it regulated abortion. Instead, the bill went straight to the Senate floor for a vote to approve the House amendments. Democratic Senators challenged the amendment, arguing that it could close up to 80% of Virginia's abortion clinics and thus significantly impede women's access to health care. Additionally, the bill did not distinguish between types of abortion. Senator George Barker (D-39) opposed the bill, in part because, "There are a number of medical abortions during

the early weeks of pregnancy. [Under SB 924] the clinics sill have to be license as a hospital ... even if it's just a physician office providing medications for medical abortions" (Terrini, 2011a).

The vote to accept the amendment was tied, 20-20, with two Democrats joining the Republicans to approve the amended bill. Republican Lieutenant Governor Bill Bolling cast a tie-breaking vote in favor on February 24th, 2011. Republican Governor McDonnell signed the bill on March 26th, 2011. After a decade of trying, the Republicans successfully passed a bill to mandate that the Virginia Board of Health regulate abortion clinics alongside hospitals, nursing homes, and certified nursing facilities. In doing so, it became the only state in which a patient would need to go to a hospital-grade facility to receive a first trimester abortion. The bill granted the Virginia Board of Health 280 days to implement a set of "emergency rules" to comply with the law.

5.6.3 Are Abortions safe? Should abortion clinics be regulated as hospitals?

The premise behind the call for these enhanced regulations is that abortions and abortion clinics are currently unsafe, and that more oversight is needed to protect the health of women seeking an abortion. Proponents of the regulations argue that abortion clinics should be regulated along with hospitals in order to protect women's health. Mallory Quigley of the Susan B. Anthony Group explained, "This is really necessary to ensure that woman are treated with care consistent with their human dignity" (Winkler 2013). Supporters of this position often make reference to the clinic of Kermit Gosnell in Pennsylvania, who was convicted of first-degree murder (3 counts) and involuntary manslaughter (1 count), after his clinic was raided in 2010 and found to have unsanitary and unacceptable practices. Abortion rights activists condemn Gosnell's clinic and contend that the conditions and practices in that clinic are anomalous relative to other abortion clinics. However, proponents of abortion

regulations, such as Victoria Cobb, President of the Family Foundation of Virginia, argue that without "common sense safety precautions" no one knows the conditions in abortion clinics operate (Schulte 2011). According to Chris Fruend, Vice President of the Family Foundation, regulations that require extensive renovation are good because "[abortion clinics] will actually have to put some profit back into their facilities ... The fact is simply that the abortion industry is about profit, not healthcare" (Robertson and Sillars 2013). These supporters of the regulations argue that because abortion clinics have a financial interest in providing many inexpensive abortions, they should not be allowed to "self regulate."

Strict regulations and inspections, in their view, protect women in a vulnerable emotional state. Testifying before the Virginia Board of Health, Leslie Blackwell explained her support for increased regulation: "When you are a young girl in crisis and you are going into that abortion center, the last thing you are doing is thinking about are safety regulations. Your head is down you are not looking at anybody. You are so ashamed; so scared. You are just hoping this doctor, this nurse is not going to hurt you" (Patterson 2014).

Opponents of the new regulation contend, first, that abortions are an extremely safe procedure and there is no public health crisis regarding the safety of abortion clinics. Overall, the rate of first trimester abortions complications requiring hospitalization is only .5%, making it safer than oral surgeries, colonoscopies, and other routine out-patient surgeries performed in physicians' offices and 14 times safer than childbirth (Bassett 2011b, O'Dell 2011, Texas Policy Evaluation Project, Guttamcher). When asked if there was a reason for the new rules, (then) Virginia Health Commissioner Karen Remley responded "No, we aren't aware of any problems" (Bassett 2012a).

Additionally, opponents of the new regulation argued that the regulations do not further any medical or safety purpose, but instead are intended to drive up the

cost of operating an abortion clinic. For example, the regulations require hospital standards such as corridors wide enough for two gurneys to pass by unimpeded, exam rooms that are 16 by 18 feet, covered front entrances and four parking spots for each procedure room. Physicians testifying before the Board described these types of requirements as "medically unnecessary and onerous" (Bassett 2012a). None of the 20 abortion clinics operating in the state in 2011 met the new building requirements (Bassett 2012a), and the Virginia Department of Health estimated that the total cost of renovation would be close to $15 million, with the cost of renovation ranging from $700,000 to $969,000 (Proposed Regulation Agency Background Document, 1/8/2013).

5.6.4 Virginia Board of Health Begins Rulemaking, First with Emergency Rules

The Health Department appointed an expert panel of six members comprised of OB/GYN department chairs from hospitals and universities to work in conjunction with the Department of Health to draft the regulations. In preparing a draft of the regulations, the panel evaluated similar regulations enacted 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 (Virginia Coalition to Protect Women's Health Press Release, 12/8/11).

According to Dr. James Ferguson, chairman of the Department of Obstetrics and Gynecology at the University of Virginia and member of the panel tasked with creating new rules, the original suggestions sent to Republican Attorney General Ken Cuccinelli were "just plain good medicine, in terms of follow-ups for patients, establishing gestational age and ensuring patient care." He contends that the revisions from Cuccinelli's office included medically unnecessary building requirements intended to apply to hospitals and surgical centers built in 2010 (Bassett 2012a). The Board of Health moved forward with the revised regulations from Cuccinelli's office.

The Board of Health published the "emergency regulations" required by SB 924 on August 29th, 2011 and the Board approved the measures on September 15th, 2011. The Board of Health membership underwent significant turnover in the previous few years, and at the time of this vote, was comprised of nine members appointed by McDonnell and six from the previous governor, Democrat Tim Kaine. At the August 29th meeting two of the Kaine appointees were absent.

After the Board published the emergency rules, they were subject to executive review and the governor's approval. Once the governor certified the rules, the regulations would take effect on January 1st, 2012 and be replaced by permanent rules a year later (Salasky, 2011). In the hour-long commenting period before the vote, 32 individuals gave public comment, with opponents of the regulations outnumbering proponents 2-1 (Beal 2011).

During the commenting period, health professionals testified on the safety of abortions. Other opponents of the regulations commented that it would make Virginia the most restrictive abortion state by essentially mandating that first-trimester abortions be performed in hospitals. Opponents noted that the policy was discriminatory for singling out abortion clinics compared to other physicians? offices, such as dermatologists and orthopedists, and cautioned that other aspects of women's healthcare may be affected, such as cancer screenings (Salasky 2011). Proponents of the regulations focused on the morality of abortion than safety. For example, one commenter showed graphic images of an aborted fetus and stated that abortion was a "grave moral wrong" akin to slavery (O?Dell 2011).

The emergency measures required that abortion clinics be compliant with three chapters of the Facilities Guidelines Institute's (FGI) 2010 Guidelines for Design and Construction of Health Care Facilities. These chapters included architectural requirements such as drinking fountains in waiting rooms, six-inch handles on all sinks, larger procedure rooms, wider hallways, sophisticated heating, cooling and

ventilation systems, covered entryways, and more parking spaces. The regulations made clinics compliant with other hospital standards, increased record keeping, and allowed for random inspections by unidentified health officials.

During the Board meeting, Board Member Jim Edmondson introduced 18 amendments to weaken the regulations, such as one to make a distinction between medical and surgical abortions. After each amendment was proposed, the Senior Assistant Attorney General Allyson Tysinger said the changes exceeded the authority of the Board (Beal 2011; Salasky 2011). Delegate Charniele Herring (D-46), a lawyer who opposed the regulations, disagreed with Tysinger's legal advice that the amendments went beyond the authority of the Board, "The heavy hand of government was at work today as the attorney general's office advised the Virginia Board of Health members that accepting some of the most reasonable amendments to the draft regulations was beyond their authority" (Kumar, 2011). According to Patrick Hurd, CEO of Planned Parenthood of Southeast Virginia, "The Board is not even seconding proposed amendments being offered. They?re so intimidated by the presence of the attorney general, they?re not even allowing these things to come up for a vote" (Bassett 2011b). The Board approved three of Edmondson's amendments that involved the timeline for relicensing, verification of the identity of inspectors, and the redaction of personal information on patient records removed from the facility for inspection. The regulations passed 12-1, with Edmonton the sole detractor.

5.6.5 Permanent Rules and the Influence of the Attorney General

The "emergency rules" went into effect January 1st, 2012. The Board proposed making the temporary regulations permanent, with few alterations on June 15th, 2012. The FGI guidelines, on which the Board's regulations were based, were written with the intention that they only apply exclusively to new hospital construc-

tion.[13] By far, the most controversial change in the proposal was to "grandfather" existing clinics and only applies the stringent standards on new and remodeled facilities. This decision was consistent with regulations the Board had previously approved, which "grandfathered" existing nursing homes and hospitals from meeting the new standards. The vote to make this change first passed by a vote of 7-4, and after more debate, the Board voted again to pass the amendment 6-5 (Brown, Dutton, Patterson, 2012).

Under Virginia's Administrative Process Act (APA), the proposed rule would next be submitted to the Department of Planning and Budge (DPB) for an economic impact analysis. After that, it would be subject to a 60-day public comment period before going to the Governor for final approval. However, Governor McDonnell took an unprecedented step in 2010 of issuing an executive order (McDonnell 2010) that required each proposed regulation receive certification from the Attorney General that stated that agency has the legal authority to promulgate it before getting submitted to the DPB. This executive order gave significant veto power to Attorney General Ken Cuccinelli. By refusing to certify any specific regulation, the rule would not be sent the DPB, and any subsequent steps in the rulemaking process.

On July 16th, 2012, Cuccinelli issued a statement that the Board "exceeded its authority" in by allowing existing facilities to be exempted from the new standards. In a memorandum from Senior Assistant Attorney General Allyson Tysinger to Dr. Karen Remley, the Commissioner of the VA Department of Health, the Attorney General stated that while the grandfather clause was in place, the rule conflicted with the revised code based on SB924, and thus would not be certified.[14] Cuccinelli's

[13]The FGI state that they are "intended as minimum standards for designing and constructing new health care facility projects" (FGI Guidelines 1.1-1.3.2).

[14]"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." (Greenier and

memorandum was controversial, and opponents to the regulations argued that he was the person exceeding his authority. According to Katherine Greenier, Director of the ACLU of Virginia's Women's Rights Project:

> "While the Attorney General has the responsibility to review proposed regulations to determine if the Board has the authority to adopt them, the law does not give his Office veto power over the Board's policy decisions about what to include in the final rules. This is a forced interpretation of the law aimed at advancing the Attorney General's anti-choice views" (Bassett 7/17/12)

The Attorney General's office defended the decision to not certify the Board's proposed rule. Brian Gottsein, spokesman for the Attorney General, argued that the decision not to certify was not politically motivated or related to Cuccinelli's beliefs about abortion, "Our office merely reviews the regulations and certifies whether they are complaint with the law or not" (Bassett 2012c).

The same day that Cuccinelli issued his first memorandum, Governor McDonnell appointed a new member to an open seat on the Board of Health. The new appointee, Dr. John Seeds, was one of the obstetricians on the panel originally asked with creating the rules. However, abortion rights activists argued he was too biased to be an appropriate addition to the Board. Seeds was also Vice Chairman of Virginia OBGYN's For Life and had previous stated his beliefs that, "Abortion is the voluntary killing of human life that requires, in my opinion, turning away from God and his love" (Sheppard 2012). Despite these objections, the legislature confirmed Seeds? appointment.

5.6.6 The Board Convenes to Reconsider the Rules and the Aftermath

Cuccinelli sent a second memorandum to the Board of Health on September 12th, 2012, which stated that the Board was not required to follow the advice of the

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Glenberg 2014)

Attorney General, and that the Attorney General could deny state legal counsel to Board members that did not follow his advice about relaxing the regulations (Walker 2012). This almost certainly persuade some Board members to vote against grandfathering existing clinics, including Board chairman Bruce Edwards, who said, "I?ve learned a long time ago that if the attorneys advise me to do something in a certain way, that's the way I do it" (Walker 2012). This led to claims that his refusal to legally represent Board members facing lawsuits amounted to a blatant threats and intimidation that forced Board members to change their position.

Leading up to the Board meeting, interest groups on both sides of the debate tried to rally support. The Family Foundation of Virginia issued a scathing report that summarized violations from clinic inspections. The report listed violations such as "untrained staff, unsanitary conditions, improperly labeled and stored drugs, and blood on equipment" and are a sign of "complete disregard for the health and safety of the patients going to these centers" (Family Foundation 2012a). The Virginia section of the American College of Obstetrics and Gynecology (ACOG) independently funded a public letter and advertisement to be placed in the Richmond Times-Dispatch. They referenced the exemplary safety records of clinics, the "onerous and medically unnecessary architectural requirements," and pled for the Board to remain politically impartial:

> "As an independent agency, the Board has always acted with integrity and impartiality. Recently, however, political forces have challenged the independence of the Board. We appeal to the Board to resist these outside influences and urge the Board to make its decision on the basis of impartial, professional and scientific information as it relates to the women's health clinic regulations. The reputation and credibility of the Board is at stake." (ACOG Virginia, 2013)

The Virginia Board of Health reconvened on September 14th, 2014, two days after Cuccinelli's memorandum to the Board of Health. Edmondson, once again,

proposed a series of amendments aimed to exempt current clinics or allow the State Health Commissioner greater discretion to grant variances, but these amendments also failed 13 to 2. Edmondson and H. Anna Jeng, the other Board Member to vote against the new rule, urged their fellow board members be uninfluenced by Cuccinell's threats to refuse legal representation (Vozzella 2012). The Board voted 13 to 2 to issue the rule without the "grandfather" clause for existing clinics.

Immediately after the Board's decision, Victoria Cobb from the Family Foundation of Virginia said that the claims from regulation opponents that the regulations would force clinics to close was "hysterical." In a statement following the vote, Cobb said: "We are pleased that the Board wasn't fooled by the abortion industry's distractions from the real issue of abortion centers in Virginia found with bloody patient tables, unsanitized conditions and untrained staffs" (Family Foundation 2012b).

Governor McDonnell certified the Board-proposed regulations on January 1st, 2013 and posted the announcement to a government website with little fanfare on the Friday between Christmas and New Year's holidays (Nolan 2013a). The governor's action triggered another 60-day public commenting period. Between January 28th, 2013, and March 29th, 2013, nearly 3,000 individuals submitted comments online and the Board held two public hearings. The Board of Health officially passed the permanent resolutions on April 12th, 2013, again rejecting an amendment that would grant more time for clinics to become compliant. The permanent rules went into effect in June 2013, and clinics had to be in compliance by June 30, 2014.

The Health Commissioner had authority to grant a variance to a clinic if the Commissioner believed a requirement would be an undue burden and would not jeopardize patient safety and public health. However, in the aftermath of the Board's vote in September, Dr. Karen Remley resigned as the Virginia Health Commissioner. In her resignation, she explained that:

> "How specific sections of the Virginia Code pertaining to the development and enforcement of these regulations have been and continue to be interpreted has created an environment in which my ability to fulfill my duties is compromised and in good faith I can no longer serve in my role" (Meola 2012).

McDonnell appointed a new Health Commissioner, Dr. Cynthia Romero, effective January 30th, 2013.[15]

5.6.7 A New Governor Brings Review of Rules

By state law, governors in the state of Virginia cannot serve consecutive terms. The 2013 gubernatorial election was a close contest between Democrat Terry McAuliffe and the incumbent Republican Attorney General Ken Cuccinelli. The new abortion regulations and the "Republican War on Women" were prominent themes in the election, particularly because of Cuccinelli's central involvement in the Board's proceedings. Five of the state's 23 abortion clinics had closed or stopped providing abortions because of the cost of renovations (Bassett 2014). Of the remaining 18, 13 have sought temporary waivers from the rules, and five clinics were able to comply with the architectural standards (Portnov 2014a).

Terry McAullife won the gubernatorial election. On May 12th, 2014, Governor McAuliffe fulfilled a campaign promise by issuing an executive director that called for a review of the clinic regulations. In the directive, McAuliffe called for the Secretary of Health and Human Resources and the State Health Commissioner to "initiate a periodic review of those regulations ... and determine whether any new regulations, amendments, or a repeal of all or part of the regulations, is appropriate" to be completed by October 1st, 2014 (McAuliffe 2014). Without the directive, the regulations would have faced a review in 2017.

[15]When McDonnell was indicted the following year for illegally accepting gifts, it came to light that Romero rented one of McDonnell's family homes.

At the same time he replaced five of the Board of Heath members, and another member a few months later. McAuliffe was criticized for politicizing the Board when he asked several Board members that voted for the regulations to vacate their seats a month early (Walker 2014b). Several months earlier, he had appointed Dr. Marissa Levine to be the new Health Commissioner. McAuliffe's appointment of Levine was also controversial. Levine was the target of many Republicans and conservative family-oriented interest groups because she is transgender.[16]

The first step in the review was for the Health Commissioner to solicit comments during a 45-day commenting period, and offer a decision based on the feedback regarding whether the regulations should be retained, amended, or repealed. On October 1st, 2014, Levine announced her decision that the regulations should be amended. She said that of the nearly 15,000 comments offered during the 45-day commenting period, more than 10,000 comments requested the regulations be repealed outright. She also said that she does not believe the Board has the authority to repeal the regulations outright, but that the regulations should be amended so that they are "aligned more accurately with medical best practices" (Portnov 2014a). The recommendations concern amending the construction and design rules, rules for drug storage, improving standards for medical testing, emergencies and anesthesia and clarifying parental consent requirements (Pornov 2014a; Monfort 2014; Liss-Shultz 2014).

On December 4th, 2014, the Virginia Board of Health voted 13-2 to begin a

[16]The Virginia Christian Alliance issued a statement on November 29th, 2014, after Levine had been named as the interim Health Commissioner: " There are serious issues with Dr. Levine, both enforcing Virginia Law, and in his (or her) personal struggle with "his" gender identity. When a man looks in the mirror and sees a woman, he has serious issues. Dr. Levine should find a job in the private sector; not in a state position requiring public faith and trust." At the December 4th, 2014, Board of Health meeting, the Republican nominee for Lieutenant governor in 2013, E.W. Jackson, said, "His is the. transgender commissioner of health appointed by Gov. [McAuliffe]. Formerly a married MAN (Mark) with children, now Marissa. Needless to say ... very pro-abortion" (Portnoy 2014b).

review process to amend the newly established regulations. Governor McAuliffe applauded the decision in a statement of support that blamed the "onerous regulations" on the "result of politics being inserted into the regulatory process" (Pornov 2014b). While the review takes place, which could be up to two years, the existing would stay in effect. A new public commenting period was open from January 12th, 2015 to February 11th, 2015. This case is still ongoing. The Board will meet in June 4th, 2015, to discuss proposed changes.

Some Republicans in the Republican-controlled Virginia House of Delegates have tried to halt the review of these regulations. On February 13th, 2015, Delegate Marshall attached an amendment to a budget bill that would block the Board of Health from amending the regulations. Referring to the review currently underway, Marhsall stated, "I don't think they [the Board] have the competence to do this" (Lachman 2015). When questioned by Delegate David Albo (R-42) if his amendment would also block changes he liked, such as anti-abortion rights oriented, Marshall responded sarcastically that, "If the McAuliffe administration is gonna start putting pro-life amendments on abortion clinics regulations, I will go to church every day and kneel for six hours" (Lachman 2015). Because the governor may use a line-item veto, the amendment was more grandstanding than an actual threat to the process.

5.6.8 New Attorney General Brings New Legal Opinion

Health Commissioner Levine requested that the new Attorney General issue an opinion on whether or not the Board of Health can require that facilities in existence before the enactment of regulations must satisfy the new standards. On May 4th, 2015, Attorney General Mark Herring issued an opinion that opined that,

> "Given the plain language of the statutes, the Board's longstanding interpretation that design-and-construction standards have only prospective effect, and the intent of the Guidelines and USBC to apply only to new construction, it is my opinion that the Board of Health lacks the au-

> thority to impose new design-and-construction standards on pre-existing facilities" (Herring 2015).

The Attorney General's legal opinion is non-binding, but it may shift the votes of Board Members as they vote in June 2015. As Chairman Bruce Edwards said in 2012 reference to Cuccinelli's legal opinion, he has learned, "I've learned a long time ago that if the attorneys advise me to do something in a certain way, that's the way I do it" (Walker 2012).

5.6.9 TRAP Laws in Virginia and Other States

The future of the Targeted Regulation for Abortion Providers passed by the Virginia General Assembly in 2011 and implemented by the Virginia Board of Health in 2011 and 2013 is uncertain. As the new Board of Health continues its review of the regulation, it is very likely that the rule will be repealed or amended in such a way as to apply only proactively to future clinics and renovations. The regulatory review process in Virginia can take up to two years, and in the meantime, the regulations will remain in effect.

5.7 What These Cases Tell Us About Bureaucratic Involvement

What do these cases tell us about why and how bureaucracies take advantage of the broad authority already granted to them to enact policy change unprompted by the legislature? Despite significant differences in the details of the abortion rule-making in the three cases, there are several important commonalities in the legislative and executive branches, and to a lesser extent, the role of public opinion and interest groups.

There is a pattern of *legislative conflict* that results in multiple failed attempts to pass a bill. The conflict isn't a conflict between the parties, and it isn't necessarily between branches of government. Instead, key figures in the legislature block the bills

from getting floor votes and passing. In Georgia, Republican House Speaker Ralston refused to schedule the insurance bill for a vote. In Virginia, the Democrat-controlled Senate Education and Health Committee blocked every abortion bill they received. In order to circumvent the committee's gatekeeping, House members strategically added language regarding abortion to a Senate bill, which sent the bill to the floor for a vote instead getting referred to committee.

As frustration in the legislative conflict mounted, sponsors of failed bills, governors and interest groups speculated about the possibility of strategically implementing the policy through bureaucratic rules. In Iowa, Governor Branstad speculated in an interview leading up to his reelection about the role the governor could have in ending telemedicine. The frustration was even more evident in Georgia, where Senator Crane (the sponsor of a failed bill), Governor Deal and the Georgia Right to Life all issued statements discussing the "executive solution" of changing the state health benefits plan.

In each state, abortion was prominent on the *executive's agenda.* The abortion dilemma facing the state was discussed in the gubernatorial elections, and the governors made substantial changes to Board membership once in office. Members of the executive, such as the governor or attorney general, actively encouraged the Board to enact the rules. In some cases the governor's influence was implicit, such as in Iowa where the governor appointed well-known anti-abortion rights activists. In other states the executive's actions were explicit, such as in Virginia, where the Republican attorney general threatened to withhold legal counsel. Later, the newly elected Democratic governor asked Board members who voted for the regulations to resigned from the Board before their terms expired, and ordered a review of the rules.

The executive's influence over the bureaucracy is contingent on having a Board willing to make rules at the behest of the executive. This influence over the Board may be especially strong in states with shorter terms as board members may be interested

in reappointment and so take actions preferred by the executive. Furthermore, short-term limits allow the governor to replace the entire Board within the governor's term in office.

Two other patterns emerged that pose possible avenues for future research. The first question concerns the role of public participation in the rulemaking process. The public was completely excluded from the Board's action in Georgia, but the Boards in Iowa and Virginia did hold public commenting periods in which members of the public could testify in person or post comments to an online town hall. However, it is unclear what, if any, influence the public's testimony had on the Board's actions. News descriptions of the content of the comments and testimony indicate that opposition to the rules significantly outweighed support in all of the cases.

Interest groups were involved in all three cases. Based on newspaper coverage of interest group participation, all of the professional medical associations were opposed to the abortion rules. The anti-abortion rights groups seemed to be early participants in the process, and pro-abortion rights groups seemed to dominate participation in the later stages. It is important to note that these observations may simply be an artifact of the news coverage. However, future research can take advantage of the public nature of the commenting period to quantitatively analyze the individuals and groups that participate in this part of rulemaking, and whether the influence of these groups shapes the Board's likelihood of adopting rules.

The exploratory and descriptive nature of this project leaves significant room for improving this research in future iterations. The findings from this project are suggestive of patterns that are associated with bureaucratic activism on the issue of abortion, but the small number of cases limits my ability to draw firm conclusions. In future work, I plan to extend the qualitative research to several more states. In particular, documenting the involvement of state health boards in Ohio, Texas and West Virginia (state that have recently adopted abortion rules, but whose interactions with

state health boards are unique) may help shed light on some of the patterns observed in Iowa, Georgia and Virginia. Additionally, I plan to study the publicly available public commenting data to gain leverage on the participation and involvement of the public and interest groups on this type of rulemaking.

This project shows a side of policymaking rarely studied. Substantive policy changes are made in the "fourth branch" of government, and it is important to better understand more about when and how this happens. The findings indicate that bureaucratic rulemaking is a dynamic process that is significantly influenced by conflict in the legislature and pressure from the executive. Additionally, the cases suggest that interest groups bring abortion issues to the Board's agenda, and that influence from the public on rulemaking may be limited.

CHAPTER 6
CONCLUSION

About 40% of American women will have an abortion at some point in their life (Rose 2007). It is one of the most common minor surgeries performed in the U.S. With a complication rate of less than .25%, it is also one of the safest procedures (Upadhyay et al 2015). The complication rate for a first trimester abortion is similar to that of a colonoscopy, and lower than the complication rate than wisdom tooth removal or tonsillectomy (Upadhyay et al 2015).

Despite this, state policy makers are exceptionally active on the issue of abortion. Policy makers and interest groups justify these types of restrictions in the name of protecting women's mental and physical health. These policies take many different forms, including policies that regulate clinic facilities, enact gestational bans that limit first-trimester abortions, increase waiting periods, and restrict the distribution of abortion inducing medication. States enacted more restrictive abortion policies between 2011 and 2013 than the entire previous decade (Guttmacher Institute, 1/2/14). Yet, mass public opinion on abortion has remained relatively stable since the 1970s with most Americans favoring legal abortion with some restrictions. This poses a motivating puzzle for my dissertation: why are states continuing to increase abortion restrictions in the absence of demand from the public or a public health crisis?

The purpose of this dissertation is to better understand abortion policy in the states. I comprehensively examine the formation of state abortion policy across policy types, over time, and in the different stages of policymaking. I find that the stages of the policy making process invokes different incentives for legislators, and as a result, the determinants of abortion policy in each stage of policymaking are different. Despite obvious differences across policy stages, I find a common theme: abortion policy is made in strategic ways, at the margins of the policy making arena,

and excluding the preferences of the mass public.

6.1 Summary of Findings

In the first empirical chapter, I look at the first stage of the policy making process. I test competing explanations for why legislators introduce abortion-related bills given that they are unlikely to pass and expend legislators' limited time and resources. Using a dataset of abortion bill sponsorship from 2000 to 2010, I find evidence that the determinants of bill sponsorship are contingent on the legislator's gender and party identification. For example, I find that the effect of interest group contributions is limited to certain groups. Contributions from anti-abortion rights interest groups increase a male legislator's likelihood of introducing restrictive abortion policy and contributions from pro-abortion rights interest groups increase Democratic women's likelihood of introduction liberal abortion policy. I find that conservative constituent ideology only weakly influences a legislator's bill sponsorship, but it actually makes restrictive abortion bill introduction *less* likely among Republicans. The only time constituent ideology influences legislator behavior in an intuitive way is that Democratic men in liberal districts are more likely to introduce pro-abortion rights policy.

Next, I explore the diffusion of abortion policy across the states. Previous research on the diffusion of anti-abortion rights policy came to mixed conclusions about the determinants of state policy adoption, depending on the type of policy examined. I use an original dataset of 29 anti-abortion rights policies and 8 pro-abortion rights policies to simultaneously identify a set of predictors of state abortion opinion that is less susceptible to case selection bias than previous work. I find that both public opinion and partisan factors explain restrictive policy adoption, but that conservative public opinion only shapes policy when Republican control of the legislature is strong. I also find that partisans strategically focus their attention on

certain types of abortion policies. For example, Democratic women do not make pro-abortion rights policy more likely and only prevent the adoption of specific abortion policies.

In the final empirical chapter, I study how state bureaucracies take advantage of the broad authority granted to them to enact policy change unprompted by the legislature. Using the cases of telemedicine abortion in Iowa, insurance bans in Georgia, and clinic facility regulations in Virginia, I establish two common patterns. In each case, there is a history of legislative conflict over abortion in the state legislature. Republicans' repeated attempts to pass bills were stymied by gatekeeping individuals and committees. Their co-partisans often thwarted these efforts. For example, in Virginia, legislative success required strategic maneuvering by Republican senators to circumvent a powerful Senate committee. Additionally, abortion was prominent on the executive's agenda. Governors campaigned on the issue of abortion. Once in power, they replaced health agency officials with like-minded members and directed the bureaucracy to create rules regulating abortion in a certain way. The success of the executive's agenda was contingent on having a health board willing to make rules at the behest of the executive. I also find evidence suggestive of two additional patterns: interest groups were very involved in the rulemaking process and the influence of the public's preferences was minimal.

Collectively, the chapters in this dissertation show how political actors' involvement varies across the stages of the policymaking process. At each stage, the influence of public preferences was secondary to the role of other political and partisan factors. Instead, policy was driven by the strategic involvement of key partisans and interest groups.

6.2 Contributions and Caveats

This dissertation makes several contributions. I make a theoretical contribution to the public policy literature by shedding light on the hidden actors in the policymaking process. First, few studies consider the role of interest groups in the formation of abortion policy. The effect of interest groups on the agenda setting stage is particularly interesting. Interest group contributions increase the likelihood that certain partisans introduce abortion policy. Additionally, I shed light on an understudied venue for policymaking—the bureaucracy. I show how bureaucracies in the state enact policy that was unable to pass the legislature. This is of particular importance because bureaucratic rulemaking is insulated from the public's influence. While there is often a public commenting period before a rule is adopted, the people do not elect bureaucrats and rulemaking process is less visible to the public.

I also make an empirical contribution by creating four substantial datasets relating to state pro- and anti-abortion rights policy. Most existing scholarship focuses on only a few conservative policies at discrete moments in time, even though abortion interest groups such as NARAL and the NRLC consider some 40 different policies to be "significant." I create two original datasets that cover abortion policy: (1) all bill introductions in the states from 2000-2010 that relate to abortion and (2) the adoption of 40 policies from 1973-2013. I also create data on two key predictors of abortion policy: (3) interest group contributions at the chamber and individual legislator level from abortion-related PACs, and (4) I create dynamic state-level estimates of public opinion using multilevel regression and post-stratification (MRP). These datasets can be used in other projects that study focus on different aspects of abortion policy, bill sponsorship, policy diffusion, interest groups and public opinion.

Like any project, there are several caveats to these findings. This dissertation studies how the legislature, the executive, the bureaucracy, and interest groups shape

abortion policy, but it largely ignores the role of the courts. This is a serious omission given that state policies must respond to federal and state courts. States may play particular attention to the circuit courts, which have heard more cases regarding abortions in recent years than the federal Supreme Court.

This approach to studying policymaking across the stages of the process implicitly assumes that the policymaking in each stage in independent of the others. This is certainly not true. A policy considered in one branch of government or stage in the policy process may be influenced by other stages. For example, states cannot adopt policies in the legislature that are not first introduced, nor will the legislature adopt a policy that the Supreme Court said is not permitted. There may also be dependence within the policies themselves. A state that has successfully enacted one gestational ban may be more likely to adopt another, earlier gestational ban. A state with a policy that mandates parental consent may be less likely to adopt a policy that mandates parental notification.

6.3 Next Steps

This dissertation will become part of a larger book project, in which I plan to address several lingering questions. I am interested in further exploring innovation in abortion policy. I believe that addressing this question entails multiple parts. First, I plan to create measures that calculate the innovativeness of state abortion policy. Previous research on state policy innovation finds that some states are innovators (the first to adopt policies) and other states are followers that adopt policies much later or not at all. After establishing which states are abortion policy innovators, I plan to show how these states influence the adoption of policies in other states. Additionally, I am interested in how interest groups create model legislation that is then modified and adopted in the states. I plan to study where interest group model legislation first emerges—do interest groups create and distribute new policy ideas *or*

do interest groups find popularize and facilitate the passage of policy ideas created elsewhere.

I plan to add additional chapters on the policy feedback effect of abortion policies on state abortion rates and abortion clinics. Other scholars have evaluated the effect of abortion policy on state abortion rates. Abortion policies increase the cost and inconvenience of obtaining an abortion; therefore, policy adoptions may discourage women from getting an abortion thus decreasing abortion rates. The previous research on this question is heavily debated and focuses on key policies that may not be generalizable. Certain policies may also encourage abortion clinics to close. Several states have adopted policies that increase the cost of abortion clinics remaining open, like the Virginia law discussed in chapter 5. States, including South Carolina, Kansas, and Texas, adopted similar laws, which resulted in the closure of several clinics. I plan to study how the closure of abortion clinics influences abortion rates and support for abortion policy in neighboring states.

Finally, state supreme courts, federal circuit courts, and the U.S. Supreme Court all influence abortion policy. These Court decisions influence all stages of the policy process. The substantive text of abortion bills may change in response to Court decisions. For example, when a federal circuit court rules that a law can not be upheld as written unless it has a certain exception, legislators introducing bills in other states in the may incorporate those exemptions into the text. If a state or federal court rules that a certain type of policy is not constitutional, then the diffusion of that policy will be truncated in the states covered by that court.

6.4 The Impact of Abortion Policy on American Women

It is important for researchers to gain a better understanding of abortion policy because the number of women affected by these policies is not small. Approximately 40% of all American women will have an abortion at some point in her life (Rose

2007). One of the most problematic and well-documented abortion restrictions effects is the disproportionate effect these policies have on specific groups of women. In his dissenting opinion in *Harris v. McRae* (1980),[1] Justice Thurgood Marshall noted that the Hyde Amendment was "designed to deprive poor and minority women of the constitutional right to choose abortion" (*Harris v. McRae* (1980), 344).

Compared with higher income women, poor women are more than five times as likely to have an abortion and six times as likely to have an unintended child. (Jones and Kavanough 2011, Diner and Zolna 2011). The concentration of abortion among poor women is increasing: in 2000, 27% of women obtaining abortions had incomes below 100% of the poverty level but in 2008 this figure rose to 42% (Jones, Finer, and Singh 2010). Abortion rates are also substantially higher in minority women compared to white women. Since 1994, the abortion rate has declined more for white women than minorities (Jones et al 2009). As a result, abortion is becoming increasingly concentrated among low-income minority women and these women are disproportionately affected by state abortion restrictions (Jones and Kavanaugh 2011). Abortion restrictions such as mandatory waiting periods and prohibitions on Medicaid funding also result in black, Hispanic, and low-income women being more likely to have second-trimester abortions than their white counterparts (Dehlendorf and Weitz 2011; Pazol et al 2009), incurring higher costs and greater medical risks (Bitler and Zavodny 2001).

These policies have resulted in the forced closure of many abortion clinics. Based on data from the Guttmacher Institute, at least "[fifty-eight] U.S. abortion clinics—almost 1 in 10—have shut down or stopped providing the procedures since

[1]This case concerned a challenge to the Hyde Amendment, which prohibits federal funding of abortions except in the case of incest or rape and functions primarily through Medicaid. The Court ruled that states that participated in Medicaid were not required to fund medically necessary abortions that were not federally reimbursable because of the Hyde Amendment.

2011" (Deprez 2013). Since 2008, an average of 19 clinics have closed annually, which is more than double the closure rate from 1998-2008. The closures are the result of a combination of market forces (for example, the availability of "telemedicine" abortions to be conducted, in which a physician prescribes medication over videoconferencing) and clinics are unable to comply with new regulations (such as ones that regulate architectural or landscaping standards) (Deprez 2013). In 2008, 87% of counties had no abortion provider, and this is even higher in the Midwest (94%) and South (91%) (Jones and Kooistra 2011). This access issue is exacerbated in that fewer than 1 in 10 abortion clinics are in predominantly black communities (Guttmacher Report 1/2011), despite the abortion rate for black women (50 per 1,000 women) being substantially higher than white (11 per 1,000 women) or Hispanic women (28 per 1,000) (Cohen 2008).

CHAPTER 7
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APPENDIX A
ADDITIONAL MODELS

A.1 Additional Models for Agenda Setting

Table A.1: Percent of Gender-Party Combination Receiving Contributions

	Rep. Men	Rep. Women	Dem. Men	Dem. Women
Pro-Abortion Rights Group	.78	3.63	6.42	22.95
Anti-Abortion Rights Group	7.91	7.91	1.98	.75

Table A.2: Count of Abortion Rights Bills, by Chamber

	M12 Only NH, MA, WV
Count of Abortion Bills	
Republican Man	0.076
	(0.070)
Republican Woman	0.146*
	(0.086)
Democratic Man	-0.216***
	(0.081)
Percent Bush Vote in District	0.003
	(0.004)
Anti-Abortion IG Contrib. to Rep.	0.504***
	(0.175)
Anti-Abortion IG Contrib. in State	-2.964***
	(0.065)
Rep. Control of Legislature	-0.528***
	(0.081)
Lower Chamber	1.320***
	(0.249)
Won Less than 55%	1.145***
	(0.095)
Time Since 2000	-0.076***
	(0.012)
Even Numbered Year	-20.679***
	(0.056)
constant	-1.340***
	(0.311)
lnalpha	
constant	-0.194**
	(0.083)
N	8163
chi2	288620.33
aic	10919.61

Note: two tailed-tests, * p<0.01, ** p<0.05, *** p<0.01.

Table A.3: Count of Abortion Rights Bills, by Chamber

Count of Abortion Bills	M13 Anti-House	M14 Anti-Senate	M15 Pro-House	M16 Pro-Senate
Republican Man	1.057***	1.353***	-1.762***	-0.934**
	(0.220)	(0.298)	(0.289)	(0.432)
Republican Woman	1.162***	1.656***	-1.707***	-0.278
	(0.236)	(0.322)	(0.421)	(0.459)
Democratic Man	0.069	0.157	-0.651**	-1.000***
	(0.231)	(0.322)	(0.272)	(0.299)
Percent Bush Vote in District	0.006*	-0.001		
	(0.004)	(0.005)		
Percent Gore Vote in District			0.016***	0.036***
			(0.006)	(0.011)
Republican Lower Chamber	-0.302***			
	(0.112)			
Democratic Lower Chamber			1.446***	
			(0.235)	
Republican Upper Chamber		-0.119		
		(0.123)		
Democratic Upper Chamber				0.616**
				(0.308)
Anti-Abortion IG Contrib. to Rep.	0.855***	0.807***		
	(0.183)	(0.190)		
Pro-Abortion IG Contrib. to Rep.			0.912***	1.133***
			(0.310)	(0.352)
Anti-Abortion IG Contrib. in State	-1.436***	-1.116***		
	(0.163)	(0.176)		
Pro-Abortion IG Contrib. in State			-0.523***	-0.470
			(0.141)	(0.311)
Won Less than 55%	0.248**	-0.077	1.937***	-0.182
	(0.115)	(0.150)	(0.219)	(0.358)
Time Since 2000	-0.009	0.018	0.030	0.023
	(0.013)	(0.019)	(0.025)	(0.046)
Even Numbered Year	-0.611***	-0.823***	-1.003***	-1.760***
	(0.151)	(0.152)	(0.219)	(0.462)
constant	-3.960***	-3.578***	-6.858***	-6.638***
	(0.258)	(0.426)	(0.488)	(0.716)
lnalpha				
constant	2.755***	2.246***	4.161***	2.986***
	(0.136)	(0.138)	(0.136)	(0.308)
N	49175	18551	56632	19477
chi2	431.68	331.49	392.81	90.56
aic	11719.70	5752.58	3028.12	976.72

Note: two tailed-tests, * p<0.01, ** p<0.05, *** p<0.01.

A.2 Additional Modes for Adoption

Table A.4: Estimates of Diffusion of Anti-Abortion Rights Policies, with Varying Decision Rules for Inclusion in PEHA

	M5 Anti - Fail (10)	M6 Anti - Fail (20)
Conservative Public Opinion	-0.065**	-0.058*
	(0.033)	(0.034)
Religious Adherence Rate	1.346***	1.338***
	(0.389)	(0.405)
Prop. of Republicans	-2.221**	-2.510**
	(1.116)	(1.156)
Unified Republican Legislature	0.098	0.082
	(0.140)	(0.147)
Republican Governor	0.215**	0.160*
	(0.089)	(0.093)
Prop. of Women Democrats	-6.207***	-5.610***
	(1.125)	(1.162)
Inter: Prop. Repub. Leg * Opinion	0.146**	0.161***
	(0.058)	(0.060)
Ease of Initiative	0.065***	0.066***
	(0.019)	(0.020)
State Median Income	-0.000**	-0.000
	(0.000)	(0.000)
State Population	0.000	0.000
	(0.000)	(0.000)
Prop. Neighb Prev. Adopt Pol.	1.984***	1.955***
	(0.177)	(0.182)
Years Since First State Adopt Policy	-0.090***	-0.080***
	(0.018)	(0.019)
Years Squared Since First State Adopt	0.002***	0.001***
	(0.000)	(0.000)
var(constant)	-2.781***	-3.039***
	(0.733)	(0.757)
var(Policy Number)	-0.666***	-0.821***
	(0.201)	(0.226)
N	23752	20098
Num of Policies	26	21
χ^2	313.80	282.82
AIC	5238.10	4757.47
BIC	5367.30	4884.00

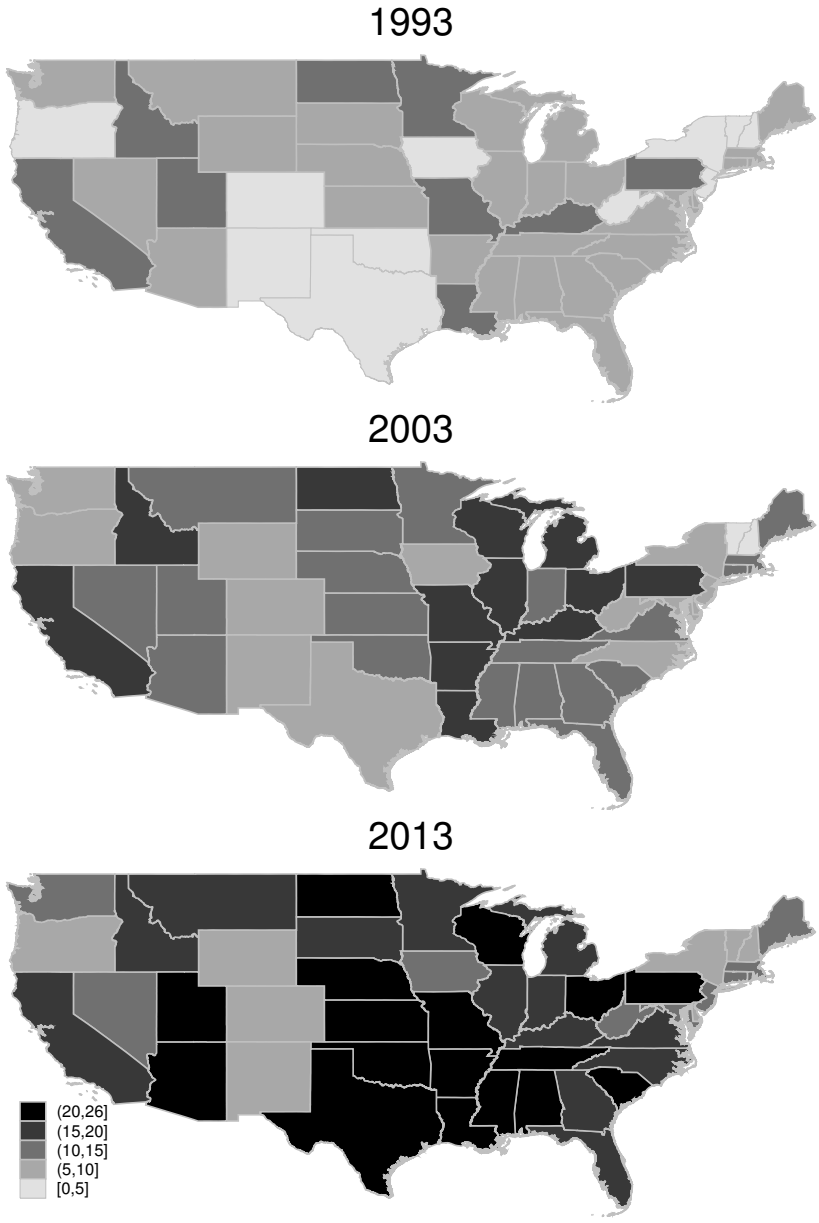
Note: single tailed-tests, * p<0.01, ** p<0.05, *** p<0.01.
Fail (10/20) means that policies are included if diffused to 10/20 states.

Table A.5: Estimates of Diffusion of Pro-Abortion Rights Policies, with Varying Decision Rules for Inclusion in PEHA

	M7 Pro- Fail (10)	M8 Pro - Fail (20)
Conservative Public Opinion	-0.145	-0.020
	(0.122)	(0.199)
Religious Adherence Rate	0.591	4.585*
	(1.339)	(2.752)
Prop. of Republicans	0.059	5.479
	(3.749)	(5.974)
Unified Republican Legislature	-1.224***	-2.360***
	(0.464)	(0.868)
Republican Governor	-0.126	-0.474
	(0.276)	(0.445)
Prop. of Women Democrats	6.132**	5.892
	(3.014)	(5.108)
Inter: Prop. Repub. Leg * Opinion	0.117	-0.085
	(0.237)	(0.361)
Ease of Initiative	0.126**	0.182*
	(0.062)	(0.098)
State Median Income	0.000**	0.001**
	(0.000)	(0.000)
State Population	0.000**	0.000
	(0.000)	(0.000)
Prop. Neighb Prev. Adopt Pol.	-0.420	1.217
	(0.595)	(1.033)
Years Since First State Adopt Policy	0.155**	0.330
	(0.063)	(0.208)
Years Squared Since First State Adopt	-0.007***	-0.017
	(0.002)	(0.015)
var(constant)	-5.654**	-13.105***
	(2.355)	(4.988)
var(Policy Number)	-16.876	-14.140
	(0.344)	(0.421)
N	3693	902
Num of Policies	4	2
χ^2	69.87	38.68
AIC	589.27	242.77
BIC	688.70	314.84

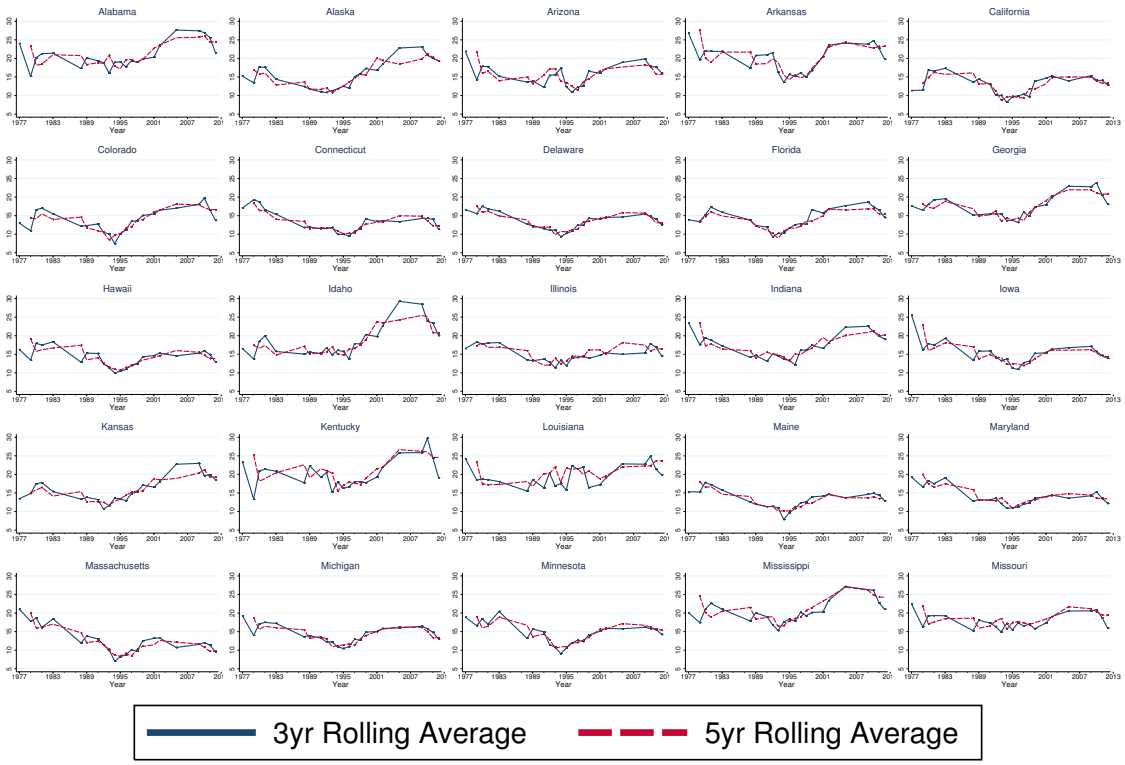
Note: single tailed-tests, * p<0.01, ** p<0.05, *** p<0.01.
Fail (10/20) means that policies are included if diffused to 10/20 states.

Figure A.1: Spread of Anti-Abortion Rights Policies, 1993-2013



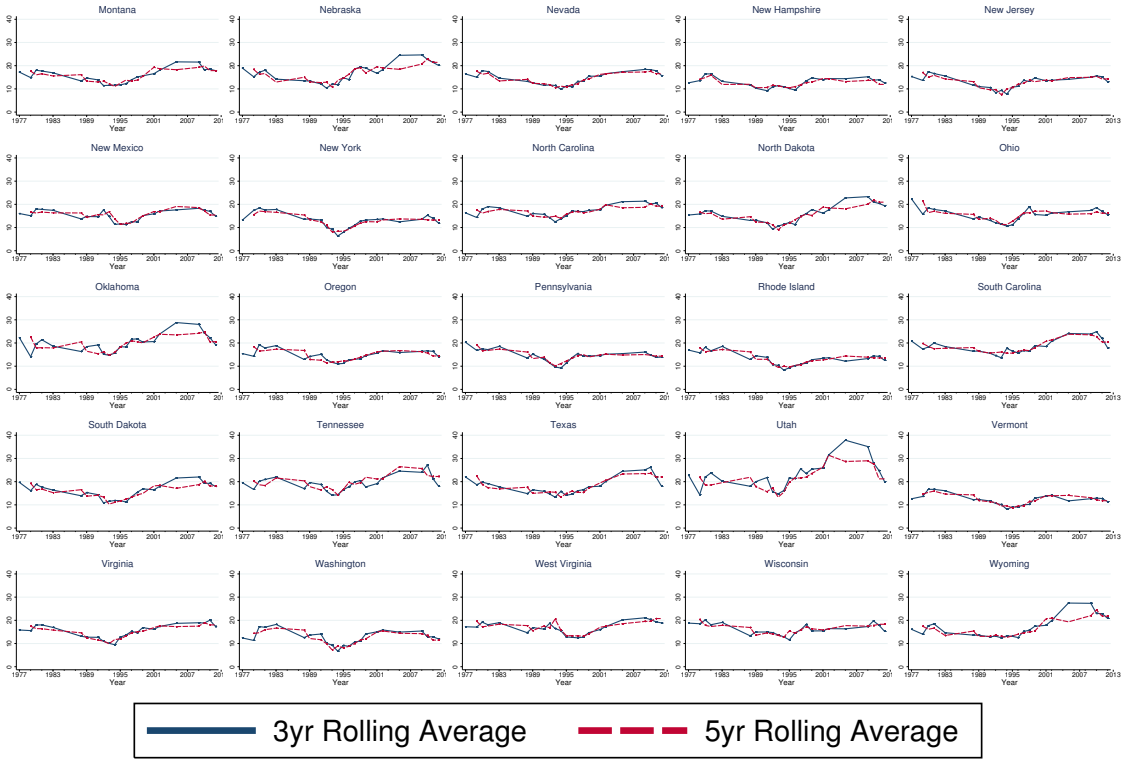
The three maps show the number of policies among the 29 included in this study adopted by each state. The number of policies adopted in the states ranges from 2-14 with a mean of 7.8 in 1993, 3-20 with a mean of 12.3 in 2003 and 6-26 with a mean of 17.2 in 2013.

Figure A.2: State Abortion Conservatism, Part 1



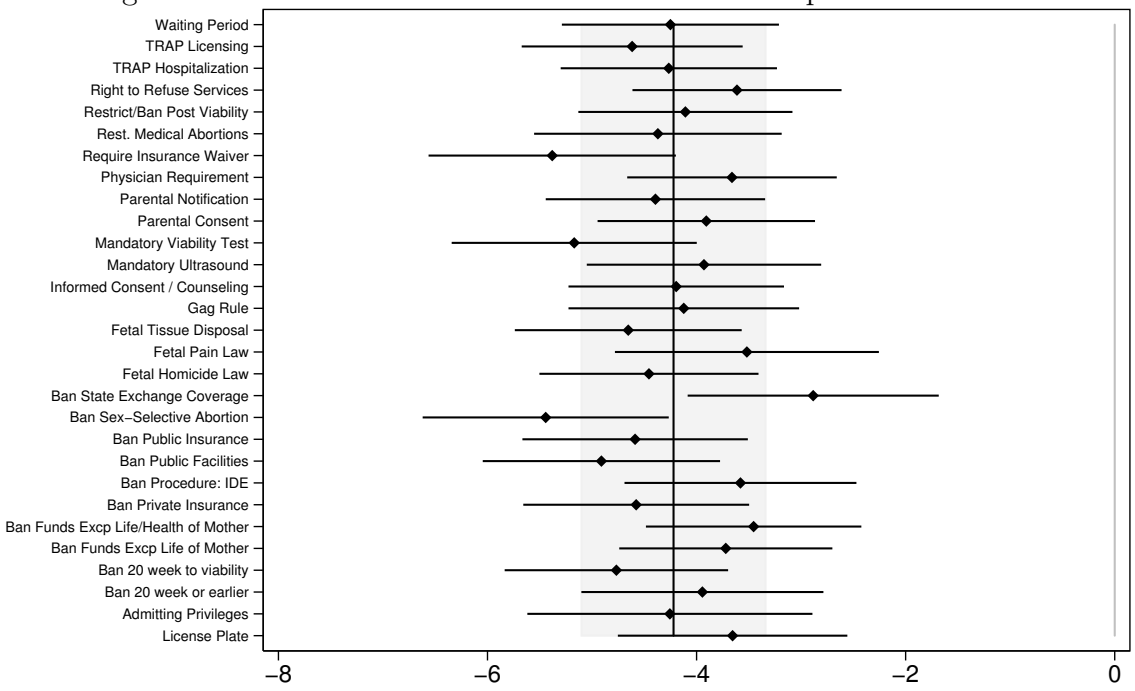
Common scale for all state legislatures. Estimated percent that believes abortion should always be illegal.

Figure A.3: State Abortion Conservatism, Part 2



Common scale for all state legislatures. Estimated percent that believes abortion should always be illegal.

Figure A.4: Standard Deviation for Random Intercepts for Policies



Notes: Points represent the combined fixed and random effect for each variable for each policy. Lines represent a 95% confidence interval based on the combined standard errors of the fixed and random effects. Black cases with diamonds are significantly difference from zero at the .05 level; medium gray cases with squares are significantly different at the .10 level; and light gray lines with circles are not. Vertical black line indicates the estimated fixed coefficient for that variable and the light shaded region gives its 95% confidence interval. Vertical grey line indicates zero.