

Reproductive Rights and Access: Massachusetts, New York, and Vermont

Sentinels Fellowship Final Report

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Abstract

Forty-four years after *Roe v. Wade*, federal and state policies continue to undermine the right to an abortion. Legal provisions target providers, institutions, and patients by creating restrictions on who may perform an abortion, imposing costly, unnecessary operating room standards, and limiting the conditions for pregnancy terminations. Massachusetts, New York, and Vermont are far less restrictive than other states in the country. However, the three states treat abortion in different ways. Vermont, for example, does not impose any restrictions at all, but New York and Massachusetts do not allow abortions after twenty-four weeks gestation. This project examines how policies relating to reproductive health, abortion access, and healthcare affect people seeking abortions in the tri-state area. Specifically, I studied access in northern Berkshire County, MA, Troy, NY, and Bennington, VT. This project provides insight into how rural communities in Massachusetts, Vermont, and New York face barriers that come from geographic isolation, expenses, and challenges in finding providers. I examined the statewide provisions that pertain to the relevant topics, visited clinics in the area, and spoke with healthcare providers and staff. In summary, the region has outstanding healthcare providers, but it is not enough, at the state level, to offer reproductive choices without also ensuring access.

Introduction

This year marks the forty-fourth anniversary of the landmark *Roe v. Wade* court decision. The outcome of this case affirmed that the constitutional right of a woman to choose to terminate her pregnancy.¹ However, politicians and various political and religious groups have continued to push back against abortion access. At the state level, for example, Targeted Regulation of Abortion Providers (TRAP) laws create barriers to safe, legal abortions. Furthermore, the new legislation has proposed budget cuts to defund Planned Parenthood², which would further complicate access to resources for family planning and women's health. These restrictions disproportionately affect women in rural, low-income areas.

The discussion around restrictions and factors limiting access to abortion focuses on states like Texas. Notably, the state has closed over twenty abortion clinics after passing a law that imposes costly facility standards and, more recently, Texas elected to ban one of the safest second-trimester abortion procedures.³ Meanwhile, states with minimal restrictions on abortion still harbor challenges in providing safe, affordable procedures. This research project investigates the politics and difficulties of obtaining an abortion in the states of Massachusetts, New York, and Vermont. The focus is on northern Berkshire County, MA, Troy, NY, and Bennington, VT. In this tri-state area, there are very different experiences for abortion providers and patients depending on their locations. Regulations that determine who may provide an abortion, for

¹ Center for Reproductive Rights, "Roe v. Wade- Then and Now," <https://www.reproductiverights.org/document/roe-v-wade-then-and-now> (Accessed April 2017)

² Elizabeth Dias, "Republicans Take Upper Hand in Fight to Defund Planned Parenthood," Times accessed April 6, 2017, <http://time.com/4626516/planned-parenthood-defund-republicans/>.

³ The Associated Press, "Texas House Approves New Limits on Abortion," *The New York Times* (May 20, 2017), <https://www.nytimes.com/2017/05/20/us/politics/texas-house-approves-new-limits-on-abortion.html?mcubz=1> (Accessed June 2017)

example, limit the number of providers. Furthermore, funding and geographic location also determine the ease of access for the pregnant person⁴.

This report presents a summary of policies and challenges that determine the accessibility of abortion in the tri-state area. The majority of this project relied on careful reading and understanding of policies relating to women's health in each state. The Guttmacher Institute and Planned Parenthood were extremely valuable sources for navigating the legal frameworks. These policies were realized in my experiences visiting clinics in the regions and speaking with nurse practitioners and staff at their respective locations. The most information is available about Berkshire Medical Center (BMC), where I work an abortion doula. The clinics in Vermont and New York were short-staffed, so many of our interactions happened over phone calls, where I called as a doula to ask about referrals and services. Unfortunately, it was extremely difficult to reach providers in Troy and other parts of Vermont, so most of the information that I have comes from their websites and other healthcare providers who shared their time with me.

First, there is an overview of abortion laws in Massachusetts, New York, and Vermont. Afterwards, there is a summary of insurance and public funding opportunities in all three states. Finally, the policies are contextualized in the tri-state region to describe how geographic and social factors interact with legal provisions. In theory, all three regions would have similar levels of access because the state policies are alike.

⁴ I refer to pregnant people, rather than women, to acknowledge the different identities that may experience pregnancy.

Legal Barriers to Abortion Access

In the decades following *Roe v. Wade*, states have continued to enforce provisions that restrict abortion access. Most commonly, states place gestational limits on procedures and most states allow healthcare providers to refuse to provide an abortion.⁵ This means that after a certain point in pregnancy, abortions may be illegal unless they are needed to protect a woman's life. Furthermore, institutions and qualified healthcare providers are not required to offer pregnancy terminations. Given the range of restrictions, it should not be too surprising that Vermont, New York, and Massachusetts enforce different regulations for pregnancy termination.

This section of the project addresses the legal framework that enables pregnant people to seek abortion in their respective states. Along the way, fieldwork details describe how the restrictions affect patients. A later section will examine the insurance policies that determine access to the procedure. It is important to note that there are many ways in which legislation may complicate abortion access. This report only explores the legal barriers that are relevant to the tri-state area.

The Provider

The World Health Organization acknowledges that most countries require physicians to provide medical and surgical abortions.⁶ Marge Berer, the international coordinator of the International Campaign for Women's Right to Safe Abortion, argues that this requirement is

⁵ Guttmacher Institute, "An Overview of Abortion Laws", *Guttmacher Institute* (updated August 1, 2017), <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws>

⁶ Berer, Marge, "Provision of abortion by mid-level providers: International policy, practice and perspectives," *Bulletin of the World Health Organization* 87 (2009): 58-63.

outdated and conflicts with the interest of providing accessible, affordable, and safe abortions. Instead, mid-level healthcare providers, such as mid-wives and nurse practitioners, are capable of providing abortions to patients. Nonetheless, thirty-eight states require licensed physicians to provide abortions at any stage.⁷ Only in 2013, California surprised the country by lifting its restrictions on physician-only abortions⁸ and allowing trained nurse practitioners, mid-wives, and physicians assistants provide care instead.

Vermont and New York are among the only twelve states that allow non-physicians to terminate pregnancies.⁹ Other healthcare professionals may provide surgical and medicinal abortions in either state. Massachusetts, however, continues to lag behind in this respect. Only licensed physicians may provide abortions, both medicinal and surgical.

In practice, the effects of these restrictions are evident for Berkshire County, MA and Bennington County, VT. The Planned Parenthood in Bennington has recently started to offer medicinal abortions and a nurse practitioner regularly prescribes the mifepristone and misoprostol pills. This has been an extraordinary change in the community. Conversations that I had with healthcare providers at Planned Parenthood and the Southwestern Vermont Medical Center (SVMC) revealed that they had referred patients to institutions in Rutland and Burlington, VT before this change. These would be a one or a two and a half hour drive, respectively, at the expense of the patient. As of August 2017, patients seeking surgical abortions or termination after ten weeks still need to make this trip.

⁷Guttmacher Institute, “An Overview of Abortion Laws”

⁸ Lovett, Ian, “California Expands Availability of Abortions,” *The New York Times* (October 9, 2013), <http://www.nytimes.com/2013/10/10/us/california-expands-availability-of-abortions.html?mcubz=1>

⁹ Guttmacher Institute, “An Overview of Abortion Laws”

Meanwhile, in Berkshire County, the recent retirement of Dr. J¹⁰ has left the abortion schedule at BMC fairly uncertain. Her practice involved providing surgical abortions once a week, but there is not a single practitioner who has assumed this role. Instead, the OBGYNs at BMC take turns providing the operation. There were several weeks this year where no procedures were provided because there were not any physicians available. In consequence, people seeking the operation had to prolong the unwanted pregnancy. Unfortunately, of course, the procedure is time sensitive.

In Vermont, healthcare providers and institutions cannot refuse to assist patients seeking abortions. If an institution does not or cannot provide the procedure, then they must refer patients to locations and people that can. As aforementioned, this requires SVMC, which does not terminate pregnancies, to direct patients to clinics and hospitals in other parts of the state.

New York, like Massachusetts, however, allows providers and institutions to opt out.¹¹ In fact, in 2009 Mount Sinai Hospital was sued by a Catholic, anti-abortion nurse for ‘forcing’ her to assist in a second-term abortion.¹² As an abortion doula in Massachusetts, I was able to observe the effects of this policy in Berkshire County. Dr. Y¹³, at BMC, refuses to provide surgical abortions. He does, however, provide medicinal abortions. This has complicated access in the last few months because his refusal forces other local physicians to make themselves

¹⁰ This a pseudonym for the previous abortion provider at BMC.

¹¹ Guttmacher Institute, “Refusing to Provide Health Services,” *Guttmacher Institute* (updated August 1, 2017), <https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services>

¹² Duin, Julia, “N.Y. nurse sues after being forced to aid abortion,” *The Washington Times* (July 31, 2009), <http://www.washingtontimes.com/news/2009/jul/31/nurse-sues-after-aiding-abortion/>

¹³ This is a pseudonym for an actual OBGYN at BMC.

available more frequently and, of course, he could not fill in during the weeks when other doctors were unavailable or unwilling to trek to Pittsfield, MA.

Gestational Period

Of the three states, Vermont is the only one that does not have a gestational restriction for abortion. Massachusetts and New York only allow termination after twenty-four weeks post-fertilization, or twenty-six weeks since the mother's last menstrual period, if the mother's life is in danger. Massachusetts will also make exceptions for health reasons.¹⁴

At twenty-four weeks, the mother is in the second trimester of pregnancy. The fetus is potentially viable at this time, with a roughly fifty percent chance of survival under intensive medical care and treatment.¹⁵ In the case that an abortion is provided at 24 weeks gestation, New York requires a second physician to attend the abortion in case the fetus is born alive in some circumstance.¹⁶

It is important to realize that this restriction only makes exceptions for the pregnant person's health. If the fetus has a fatal birth defect, the law will not protect the right to an abortion. This creates an undue burden, and an expensive one, at that, for parents who need a late term abortion provider. For example, a woman published an anonymous essay about her experience having a thirty second week abortion, for which she travelled all the way to Colorado from New York:

¹⁴ ¹⁴ Guttmacher Institute, "An Overview of Abortion Laws"

¹⁵ Glass, Hannah C., Costarino, Andrew T., Stayer, Stephen A., Brett, Claire, Cladis, Franklin, and Davis, Peter J., "Outcomes for extremely premature infants," *Anesth Analg* 120: 6 (June 2015): 1337-1351.

¹⁶ Guttmacher Institute, "An Overview of Abortion Laws"

“Still in shock over this tragic turn of events, I lay on the table, looking up at the ceiling. My internal questions played like a tape over and over in my mind: *Why am I here? Did New York expect me to carry this baby to term, only to watch him suffer and die?* Since then, I’ve tried to answer that second question. The only answer I’ve come up with is: yes.”¹⁷

Her story reveals an important reality: the majority of pregnant people seeking late-term abortions are doing so in the interest of the health of themselves or the fetus. Additionally, late term abortions are also extremely rare. In Vermont, where there are not gestational restrictions, the CDC reported that in 2013, only .5% of all abortions occurred after 21 weeks.¹⁸ Therefore, the restriction complicates access for a select few pregnant people. Currently, only seven states (and the District of Columbia) do not prohibit abortions at any stage of pregnancy: Alaska, Colorado, New Hampshire, New Jersey, New Mexico, Oregon, and Vermont.

Parental Consent

The final legal provision to consider between Massachusetts, New York, and Vermont involves parental involvement in minors’ abortions. Parental consent is mandatory for minors receiving abortions in the state of Massachusetts.¹⁹ A minor, according to the law, is a person who is less than eighteen years of age and unmarried. Only one parent needs to consent, and there are exceptions whenever the pregnant person’s life is in danger. Notably, parents must be

¹⁷ Christensen, Erika A., “New York forces women like me to carry nonviable pregnancies to term,” *Rewire* (May 23, 2017), <https://rewire.news/article/2017/05/23/new-york-forces-women-like-carry-nonviable-pregnancies-term/>

¹⁸ Center for Disease Control and Prevention, “Abortion Surveillance – United States 2013,” *Surveillance Summaries* 65:12 (November 25, 2016), 1-44.

¹⁹ Commonwealth of Massachusetts, General Laws Part I Title XVI Chapter 12 Section 12S, <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section12S>

involved even in cases of abuse, assault, incest or neglect.²⁰ However, the minor always has a right to appeal to a judge, who may then, “after an appropriate hearing, authorize a physician to perform the abortion if said judge determines that the pregnant woman is mature and capable of giving informed consent to the proposed abortion or, if said judge determines that she is not mature, that the performance of an abortion upon her would be in her best interests.”²¹

This regulation is so important in Berkshire County. The ability of teenagers in western Massachusetts to obtain these terminations depends on the support and involvement of their parents, and the need is quite high. Although Massachusetts has one of the lowest teen pregnancy rates in the country, lagging only behind New Hampshire, Vermont, and Minnesota,²² Berkshire County still has a history of high teenage pregnancy. In fact, Pittsfield’s teenage pregnancy rate is higher than the national average.²³ Furthermore, ten percent of all abortions in western Massachusetts are for teenagers.²⁴

It is difficult to calculate how parental consent in Massachusetts may affect teenagers’ decisions to have terminations. However, BMC has certainly served many minors. I have spoken with teenagers seeking abortions, and they often have supportive relatives accompanying them for the procedure. One particular experience that stands out from this summer includes a nervous mother who waited with her daughter for the abortion. The patient comforted her mother, reminding her that this was what she needed right now. While the daughter was in the operating

²⁰Guttmacher Institute, “An Overview of Abortion Laws”

²¹ Commonwealth of Massachusetts

²² Kost, Kathryn and Henshaw, Stanley, “U.S. teenage pregnancies, births, and abortions, 2010: National and state trends by age, race, and ethnicity,” *The Guttmacher Institute* (May 2014).

²³ Curtis, Elizabeth Fall, “Choice without access: Abortion in Berkshire County,” *Williams College* (2017).

²⁴ Ibid.

room, her parent explained to me that the abortion was her daughter's choice, and that even though it was not the decision that she would have made, she was determined to stand by her daughter. The patient's father did not know about the pregnancy at all. Frankly, I can only imagine how this situation would have been handled if the daughter did not have the independence and support to make her own informed decision.

Insurance and Public Funding for Abortion

State policies also determine how abortions may be funded. Medicinal and surgical abortions are both expensive without insurance. According to Planned Parenthood's website, a medicinal termination, the only type offered in Bennington County, Vermont, can cost up to \$800.²⁵ Meanwhile, in-clinic abortions at a Planned Parenthood, like the one in Troy, New York, could cost up to \$1,500 in the first-trimester. Second-trimester terminations are more expensive.

In a hospital setting, or at least at BMC, the cost of an abortion is even higher. Patients receive full anesthesia, so they are asleep for the entire procedure, and they also pay for the operating room space in addition to the surgeon's time. According to a nurse practitioner at BMC, the cost comes to roughly \$3,000 dollars for the termination. "What happens if a patient does not have insurance?" I asked. "They can't afford the procedure," she replied.

Fortunately, there are sources of funding for abortion. At the national level, the Hyde Amendment prohibits federal support for abortion except in cases of rape, incest, or danger to the mother's life. This is the result of a 1976 Congressional bill restricting Medicaid or Medicare

²⁵ Planned Parenthood, "How do I get the abortion pill?," Planned Parenthood, <https://www.plannedparenthood.org/learn/abortion/the-abortion-pill/how-do-i-get-the-abortion-pill>.

from covering abortions.²⁶ Now, forty-one years later, the restriction remains intact and so people must rely on state funding or private insurance coverage.

Massachusetts, Vermont, and New York all meet the minimum federal requirements for funding terminations in the aforementioned circumstances.²⁷ Furthermore, none of the three states impose restrictions on private insurance funding.²⁸

The issue, of course, is that not everybody has private insurance. The Affordable Care Act, has extended access to abortion, therefore, by helping individuals and small businesses afford private insurance plans. Also, within the states, there have been healthcare initiatives that have empowered lower-income pregnant people to seek the appropriate care. MassHealth, for example, allows a pregnant person with a household income of below 200% of the federal poverty line to obtain coverage. This includes much of the population of northern Berkshire County.²⁹ MassHealth covers elective abortions, and if a patient comes to BMC and is uninsured, they can most likely sign up for a plan so that the cost will be taken care of. Similarly, BlueShield of New York and BlueShield/BlueCross of Vermont cover elective abortions under all of their plans.³⁰

Nonetheless, there are cases in which insurance cannot help. These plans do not always allow people to receive coverage in other states, for instance. This may add to the reason that

²⁶ Silverman, Davida, “The Hyde Amendment: Restricting abortion coverage for 40 years,” *Planned Parenthood* (September 30, 2016).

²⁷ Guttmacher Institute, “State funding of abortion under Medicaid,” *Guttmacher Institute* (Updated August 1, 2017), <https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid>

²⁸ Guttmacher Institute, “An Overview of Abortion Laws”

²⁹ Curtis

³⁰ Abortion in Obama Care, (2017), <http://www.obamacareabortion.com/>

there are never pregnant patients from Bennington, Vermont in BMC, even though the hospital is definitely the closest location for surgical abortions.³¹ In a more extreme example, the woman from New York who travelled to Colorado for her late-term abortion paid over \$10,000 upfront to cover last minute flights, accommodations, and the actual procedure.³² Even for an in-state abortion, however, insurance will not pay for the transportation to and from the clinic. Even if someone is referred from BMC to the clinic in Springfield, MA for a second-trimester abortion, the logistics are the patient's responsibility.³³

Geographic and Social Challenges

In states with considerably few legal and financial challenges for pregnancy termination, location can still create barrier to to healthcare. In 2008, people travelled an average of thirty miles for abortion care service in the Unites States. Approximately one-third of them travelled twenty-five miles or more, and six percent travelled over one hundred miles.³⁴ This is because, nationwide, ninety percent of U.S. counties do not have clinics providing abortions, and nearly forty percent of women of reproductive age inhabit those counties.³⁵

In comparison with the national statistics, New York and Massachusetts offer better geographical access to abortion care. However, forty-four percent of New York counties did not have clinics in 2014 and forty-three percent of Massachusetts counties did not. It is worth noting,

³¹ This was revealed in an interview with a nurse practitioner at BMC.

³² Christensen

³³ BMC Nurse Practitioner

³⁴ Jones, Rachel K., "How far did U.S. women travel for abortion services in 2008?," *Journal of Women's Health* 22:8 (August 2013): 706-713.

³⁵Jones, R.K. and Jerman, J., "Abortion incidence and service availability in the United States, 2014," *Perspectives on Sexual and Reproductive Health* 49:1 (2017).

however, that ten percent and fourteen percent, respectively, of women reside in those counties.³⁶ In Vermont, on the other hand, sixty-four percent of counties do not have clinics and nearly forty percent of Vermont women inhabit those spaces. Even while Vermont has extremely prochoice state policies, access to abortion becomes complicated.

This section examines the geographic obstacles to obtaining an abortion. The project considers information about local providers, competing ideologies, and later-term abortion providers.

Local: Pittsfield, Troy, and Bennington

Counties may have hospitals or physicians that provide private care for terminations. For example, Berkshire County does not have a clinic, but BMC still provides abortion services. The statistics are relevant because nearly sixty percent of abortions nationwide are provided by clinics, even though they only account for sixteen percent of all facilities.³⁷ This may be, in part, because hospitals do not advertise their services.

At BMC, for example, patients appreciate the privacy of walking in and out of the Crane Center, which provides a variety of healthcare services. Therefore, their reason for visiting is not obvious. The downside is that many people do not realize that they can go to the hospital in Pittsfield for terminations.³⁸ By observation from myself and other doulas in the Berkshire Doula Project, many (if not most) of the patients receiving abortions are somehow affiliated with the

³⁶ Ibid.

³⁷ Ibid.

³⁸ Fieldnotes

hospital or know someone who is. In other cases, patients have expressed their surprise after they were informed that BMC could offer terminations once they learned that they were pregnant.

Troy, New York, on the other hand, has a Planned Parenthood that offers medicinal and surgical abortions.³⁹ My interactions with the staff and patients around their clinic was completely different.

Planned Parenthood has been under political scrutiny,⁴⁰ so there are noticeable safety measures around the facility. The space is difficult to find because the clinic is on an upper floor in a large building, which contains other offices. Google Maps led me to the building, but there were not any signs or people in the lobby of the building to direct me from there. Once I reached the stairs, there was a sign that helped me find the right floor. In the space, a waiting room is closed off from the rest of the clinic with closed doors, and thick glass separates the patient from the receptionist at the desk. On my way out, two women came up to me in the building's main lobby to ask if I knew where to find Planned Parenthood. The space is totally invisible unless you are trying to find it.

Similarly, the Planned Parenthood in Bennington, VT is hidden among other offices in a closed off space. The staff were extremely friendly and welcoming, but they also expressed that they were short staffed, and it was difficult to talk to anyone. Bennington only started offering medicinal abortions this year and there is a nurse practitioner who prescribes the pills, as needed. It is unclear if many people in the surrounding community even realize that the service is now available.

³⁹ Planned Parenthood, "Abortion services in Troy, NY," <https://www.plannedparenthood.org/health-center/new-york/troy/12180/troy-health-center-2780-91020/abortion> (accessed June 2017)

⁴⁰ US Congress, House - Energy and Commerce, *Defund Planned Parenthood Act of 2017*, Sponsored by Rep. Diane Black, 115th Congress, 2017.

Stigma and Pregnancy Crisis Centers

Within communities, stigma and competing ideologies can also complicate abortion access. In Berkshire county, where physicians may opt out of providing, Dr. Y refuses to offer surgical abortions and so other doctors around the community divide their time.⁴¹ Social stigma also pressures local providers to carefully select their locations, as in Troy and Bennington. However, there are other outstanding ways that communities challenge the right to an abortion.

Bennington, VT is a fairly conservative community and abortion backlash is not uncommon, a nurse practitioner from the county explained. Against SVMC and Planned Parenthood, the competing resource for pregnant women is a CareNet Pregnancy Crisis Center. The center offers pregnancy tests, ultrasounds, and pre-natal and parenting classes. However, they also claim to provide “accurate, up-to-date information” on abortion risks, procedures, and post-abortion support.⁴² Their abortion information includes an offer to help women reverse medicinal abortions.⁴³ The reversal essentially instructs women who have taken the first pill, mifepristone, to take a large dose of progesterone. The science behind this procedure is unfounded, and it creates a narrative of regret post-abortion.⁴⁴ More importantly, pregnancy crisis centers are dangerous because they often provide false information about birth control and

⁴¹ See page 6.

⁴² CareNet, “Services Provided,” http://www.benningtonpregnancy.com/index.php?option=com_content&view=article&id=7&Itemid=119 (accessed June 2017).

⁴³ As of August 2017, the information pages on the website have been taken down.

⁴⁴Graham, Ruth, “A new front in the war over reproductive rights,” *The New York Times* (July 18, 2017), <https://www.nytimes.com/2017/07/18/magazine/a-new-front-in-the-war-over-reproductive-rights-abortion-pill-reversal.html?mcubz=1> (accessed August 2017).

abortions. Instead, they offer a space to express opposition to abortion.⁴⁵ A nurse expressed her concern to me that people in Bennington are in fact excited about the pregnancy crisis center. In fact, the organization even asked the local Boy Scout troop to march with them in a local parade.

I called the crisis center this summer to ask if they would refer me to a site for an abortion. They have not answered calls during their regular hours, so I resorted to their online chat, instead. “Planned Parenthood is closed today, but I am pretty sure that I want an abortion and I know that you don’t refer people from abortions, based on your website, but where else can I go?,” I asked. “Non referral means that we can’t answer that question,” the person in the chat replied. Instead, she referred me to other CareNet centers in Vermont, including one in Burlington, which is nearly three hours away from Bennington.

Later-Term Abortions

Most abortions are obtained in the first eight weeks of pregnancy. The CDC estimates that sixty-six percent of terminations occur in the first eight weeks and over ninety percent happen by the thirteenth week.⁴⁶ For people who are eight weeks pregnant or less, medicinal terminations have a ninety-eight percent success rate, and the pill can still be ninety-three percent effective at ten weeks.⁴⁷ Medicinal abortions are generally not prescribed after ten weeks. Thus, in Bennington, anyone seeking a surgical termination or more than ten weeks pregnant must commute to a clinic in a different part of the state. SVMC informed me that they refer patients to

⁴⁵ Matson, Erin and Merritt, Pamela, “We need to talk about deceptive, regulated ‘Pregnancy Crisis Centers,’” *Refinery29* (March 17, 2017), <http://www.refinery29.com/2017/03/145835/crisis-pregnancy-center-public-fund-fraud> (accessed July 2017).

⁴⁶ Center for Disease Control and Prevention, “Abortion Surveillance – United States 2013”

⁴⁷ Planned Parenthood, “The abortion pill,” <https://www.plannedparenthood.org/learn/abortion/the-abortion-pill> (accessed August 2017)

Rutland or Bennington. These clinics, however, have their own restrictions at eleven weeks and eighteen weeks, respectively.⁴⁸ Even though Vermont does not restrict abortion care, it is still increasingly difficult to seek a provider later in the pregnancy.

Similarly, Troy's Planned Parenthood only offers terminations up to thirteen weeks and six days, and BMC refers patients to a Planned Parenthood clinic in Springfield after twelve weeks.⁴⁹ The clinic in Springfield offers abortions until the twenty-first week of pregnancy.⁵⁰ Afterwards, patients are referred to clinics in Boston.⁵¹

Conclusions: Going Forward

Legal provisions can prevent pregnant people from obtaining abortions. However, it is not enough to offer reproductive choices and freedom. Rural communities in Massachusetts, Vermont, and New York face other barriers that come from geographic isolation, expenses, and challenges in finding providers. Vermont is a model state for abortion policy; mid-level healthcare providers can provide abortions, funding is available, and there are not gestational restrictions. However, communities like Bennington are still separated from clinics and other providers. Likewise, BMC continues to support and empower people seeking abortions, but there are not easy ways to provide later-term abortions.

If states will not require abortion providers to exist within a certain geographic radius of every county, then states could greatly improve abortion care and access by offering

⁴⁸Planned Parenthood, <https://www.plannedparenthood.org/health-center> (Accessed June 2017)

⁴⁹ Curtis

⁵⁰Planned Parenthood, <https://www.plannedparenthood.org/health-center>

⁵¹ Curtis

transportation to providers outside of the resident's county. Furthermore, more work should be done to inform the public about abortion and reproductive health. This would discredit the false information offered by pregnancy crisis centers and help pregnant people to make informed decisions while seeking care.

When abortion access is inadequate, birth control and sexual health education can empower individuals in their communities. It would be of interest to explore how reproductive health policies, in general, vary within the tri-state area.

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