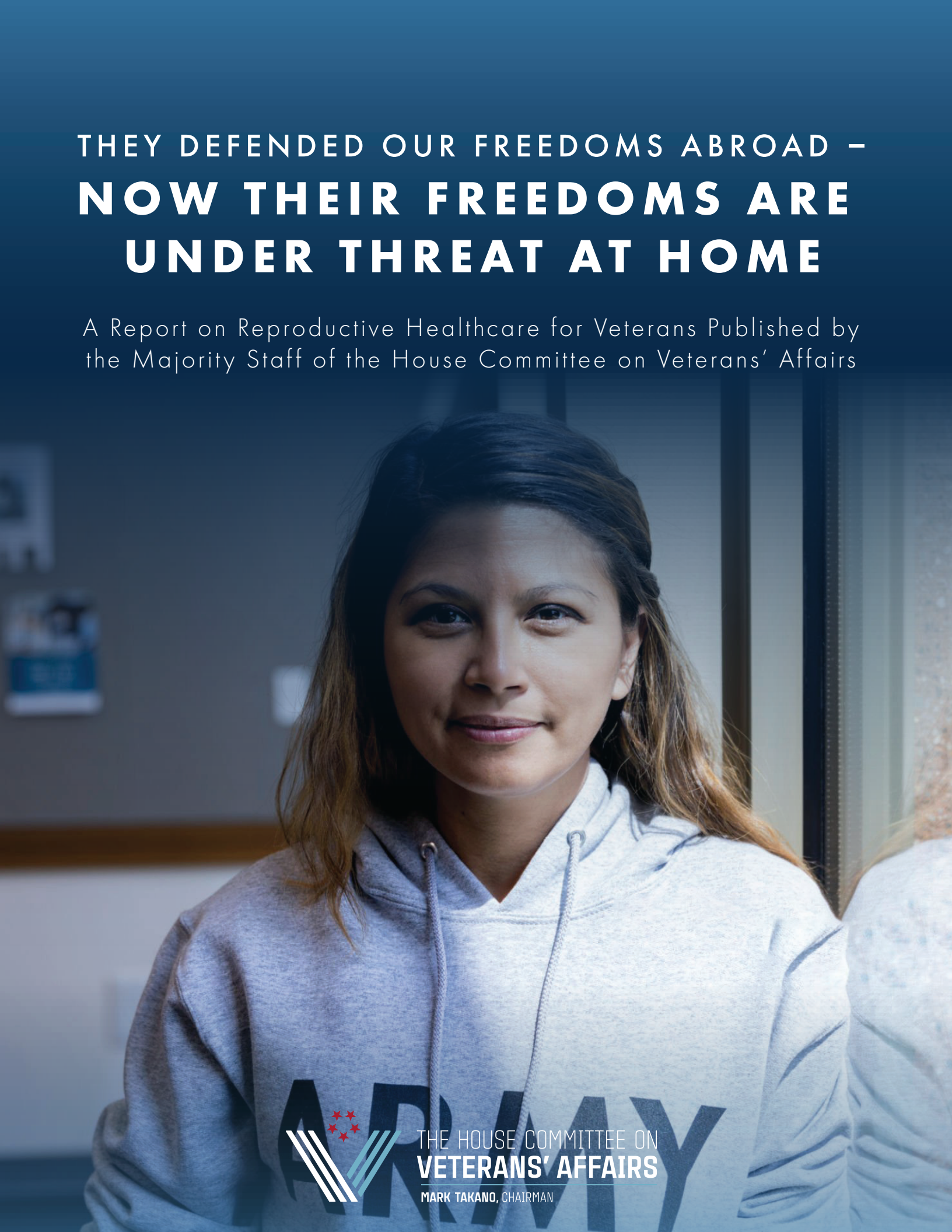
THEY DEFENDED OUR FREEDOMS ABROAD –

NOW THEIR FREEDOMS ARE UNDER THREAT AT HOME

A Report on Reproductive Healthcare for Veterans Published by the Majority Staff of the House Committee on Veterans' Affairs



THE HOUSE COMMITTEE ON
VETERANS' AFFAIRS
MARK TAKANO, CHAIRMAN

Today, more than two million living women veterans have fought for and defended our country's core founding principle: **freedom.**

It is why they served, and it is why they continue to serve in greater numbers than ever before. There is no doubt women veterans deserve our nation's gratitude and appreciation, but more importantly, they deserve access to comprehensive health care benefits, **including reproductive healthcare.**

–Chairman Mark Takano and Representative Julia Brownley

INTRODUCTION

On June 24, 2022, the U.S. Supreme Court issued its decision in the case of *Dobbs v. Jackson Women's Health Organization*, overturning the constitutional right to abortions in the United States.[1] In the wake of this decision, the U.S. House Committee on Veterans' Affairs launched an oversight initiative focusing on veterans' access to reproductive healthcare—both at U.S. Department of Veterans Affairs (VA) medical facilities and from community providers.

Women represent the fastest-growing cohort of veterans. Today, more than two million living women veterans have fought for and defended our country's core founding principle: freedom. It is why they served, and it is why they continue to serve in greater numbers than ever before. There is no doubt women veterans deserve our nation's gratitude and appreciation, but more importantly, they deserve access to comprehensive health care benefits, including reproductive health care.

Unfortunately, VA has long had the most restrictive abortion coverage policy of any federal agency, including the Department of Defense (DOD), the Indian Health Service (IHS), and the Federal Bureau of Prisons. Unlike these other entities, a VA regulation issued in 1999 has prohibited veterans from receiving abortion services at VA medical facilities and prohibited VA from paying for abortion care from community providers. It also subjected VA providers to a gag rule—barring them from discussing abortion with patients and coordinating care for patients experiencing unwanted or high-risk pregnancies and pregnancy complications.[2]

For decades, women who rely on VA for their reproductive healthcare have had to independently locate, coordinate, and finance abortion care outside of VA. As a result of *Dobbs*, that access to care has been eliminated for millions of women of reproductive age—including hundreds of thousands of veterans. With the numerous state-level abortion bans and restrictions that have been triggered since the U.S. Supreme Court's decision this past summer, patients' access to this lifesaving medical care outside of VA is rapidly diminishing.

Furthermore, the Court's decision in conjunction with other state laws and legislative proposals has also led to broader concerns about women's future access to certain forms of birth control like intrauterine devices (IUDs) and infertility services such as in-vitro fertilization (IVF). For example, the Texas Heartbeat Act, which took effect on September 1, 2021, does not on the surface appear to be applicable to IVF. However, Texas defines, "unborn child as an individual living member of the homo sapiens species from fertilization until birth, including the entire embryonic and fetal stages of development."[3] Most of the states that have banned or severely restricted abortion care have different definitions for "pregnant," "fertilization," and "unborn human being," which can be interpreted in ways that will impact fertility care. Such legal nuances will be important for VA to understand moving forward as it relies solely on community providers for veterans' access to IVF.

In late summer 2022, Committee Chairman Mark Takano and Subcommittee on Health Chairwoman Julia Brownley conducted a series of site visits to examine the effects of the *Dobbs* decision for veterans and the challenges in accessing reproductive healthcare they are now facing. Along with Majority Committee staff, Chairman Takano and Chairwoman Brownley visited six VA medical facilities in four different states. They also held seven listening sessions with veterans in six different cities and the

1 *Dobbs v. Jackson Women's Health Organization,* 142 S. Ct. 2228 (2022)

2 U.S. Department of Veterans Affairs, Enrollment Provision of Hospital and Outpatient Care to Veterans, 64 Fed. Reg. 54217 (Oct. 6, 1999).

3 Texas House Bill No. 1280 Sec 170A.001(5)

Navajo Nation. In addition, the Committee fielded a nationwide survey to gather information about veterans' past experiences accessing reproductive healthcare services at VA—including family planning, contraception, maternity care, and infertility treatment—and the future improvements they want to see. On September 15, 2022, the Committee held an oversight hearing to examine women veterans' access to the full spectrum of medical care, including reproductive healthcare, through VA. The hearing also addressed a new interim final rule (IFR) on reproductive healthcare VA issued on September 9, 2022.[4] The rule immediately allowed the Department to offer abortion counseling and furnish abortions when the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term, or when the pregnancy is the result of rape or incest. VA is currently analyzing public comments on this new rule and is in the early stages of implementing it.

This report summarizes key findings from the Committee's reproductive healthcare oversight initiative and the Committee's September 15, 2022, oversight hearing. It also includes recommendations to inform the ongoing efforts of VA leaders and policymakers to expand and strengthen veterans' access to reproductive healthcare.

BACKGROUND

With the *Dobbs* decision, the U.S. Supreme Court reversed nearly 50 years of legal precedent that had been established with its 1973 decision in *Roe v. Wade*. This immediately triggered dozens of state laws that have made it extremely difficult—if not impossible—for patients seeking abortions to access care in at least 18 states.[5] An estimated 353,000 women veterans of childbearing age reside in states where there are now abortion bans or significant restrictions.[6]

At the time of the *Dobbs* decision, no abortion services were permitted under VA's medical benefits package, a prohibition that was established through regulation in 1999.[7] VA providers were also barred from discussing abortion as an option for veterans experiencing unwanted, unsafe, or unviable pregnancies. For decades, women who rely on VA for their reproductive healthcare have had to independently locate, coordinate, and finance their own abortion care outside of VA—even in cases of threat to life or health, serious pregnancy complications, rape, and incest. With the numerous state-level abortion bans and restrictions that have been triggered since the *Dobbs* decision this past summer, hundreds of thousands of women veterans can no longer access this lifesaving medical care outside of VA. Following efforts by the House Committee on Veterans' Affairs urging the Biden Administration to take more action, the Department issued an IFR on September 9, 2022, to begin building the internal capacity to furnish abortion care at VA medical facilities, including in states where abortion is now illegal.

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4 U.S. Department of Veterans Affairs, *Reproductive Health Services*, 87 Fed. Reg. 55296 (Sept. 9, 2022) (interim final rule).

5 New York Times, *Tracking the States Where Abortion is Now Banned*, (https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html) (accessed Oct. 28, 2022).

6 This estimate is based on an analysis of the previously cited New York Times website *Tracking the States Where Abortion is Now Banned*, along with data from VA's National Center for Veterans Analysis and Statistics (see https://www.va.gov/vetdata/docs/Demographics/New_Vetpop_Model/6L_VetPop2020_State_NCVAS.xlsx). As of Oct. 29, 2022, abortion is banned in Alabama, Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, South Dakota, Tennessee, Texas, West Virginia, and Wisconsin. Abortion has restrictions related to gestational age ranging from 6 weeks to 20 weeks in Georgia, Arizona, Florida, Utah, and North Carolina. According to VA data, about 353,000 women veterans between the ages of 18 and 44 resided in these states as of Sept. 30, 2022.

7 U.S. Department of Veterans Affairs, *Enrollment Provision of Hospital and Outpatient Care to Veterans*, 64 Fed. Reg. 54217 (Oct. 6, 1999).

History and Scope of Women Veterans' Access to Reproductive Healthcare at VA

VA has provided healthcare to women veterans for decades.[8] However, it was not until the enactment of the Veterans Health Care Act of 1992 that VA's authority to provide general reproductive healthcare services to women veterans was first codified.[9] Yet this law prohibited coverage of pregnancy care, infertility services, and abortion. In 1996, the Veterans' Health Care Eligibility Reform Act provided broad authority for the Secretary to determine what kind of care is "needed" and to design VA's medical benefits package accordingly.[10] VA has since added pregnancy and delivery care to its medical benefits package, along with certain infertility services.[11] In spite of this, when VA first issued regulations to establish its medical benefits package in 1999, it continued to prohibit abortions and added a prohibition on abortion counseling.[12]

As a result, VA has had the most restrictive abortion policy of any federal healthcare program. For decades, DOD, the Federal Bureau of Prisons, and IHS have had the authority to provide abortion care to beneficiaries in instances of rape, incest, and threat to life.[13] VA, on the other hand, did not cover and could not provide abortions under any circumstance. In addition, VA providers have been prohibited from even discussing abortion as a possible option for veterans experiencing unwanted, unviable, or unsafe pregnancies.

VA is also an outlier among other federal healthcare programs and among commercial health insurers in its coverage of contraceptive medications, which are among the most used and most effective methods of preventing pregnancy. While VA offers contraception counseling and contraceptive medications as part of its medical benefits package (including oral contraceptives, emergency contraception, injections, intrauterine devices, and implants) it subjects certain veterans to co-pays for contraceptive medications, which could be up to $33 for a 61 to 90-day supply, as of 2022. In contrast, the Affordable Care Act required private and certain employer-based health insurance plans to cover contraceptive services at no cost.[14] While this law did not apply to VA or DOD, the Fiscal Year 2016 National Defense Authorization Act later required DOD to ensure contraceptive services are available to female servicemembers during healthcare visits. Active duty servicemembers using DOD healthcare incur no out-of-pocket costs for contraceptive services. This is another way in which veterans have experienced a diminution of access to reproductive healthcare after leaving the DOD healthcare system and becoming VA patients. The House has twice passed legislation that would require VA to eliminate its contraceptive co-pays, but the Senate has not taken further action on the measure during the 117th Congress.

VA has had limited authority to provide fertility counseling and treatment to veterans since 2016. Through annual appropriations measures, VA is able to cover IVF for veterans whose infertility results from an injury or illness sustained during their service. However, most veterans with infertility are

8 U.S. General Accounting Office, *Actions Needed to Insure [sic] That Female Veterans Have Equal Access to VA Benefits*, HRD-82-98 (Washington, D.C.: Sept. 24, 1982).
9 Pub. L. No. 102-585, § 106, 106 Stat. at 4947.
10 Pub. L. No. 104-262, § 101, 110 Stat. at 3178.
11 U.S. Department of Veterans Affairs, *Enrollment – Provision of Hospital and Outpatient Care to Veterans*, 64 Fed. Reg. 54217 (Oct. 6, 1999); U.S. Department of Veterans Affairs, *Medical Benefits for Newborn Children of Certain Women Veterans*, 76 Fed. Reg. 78569 (Dec. 19, 2011); U.S. Department of Veterans Affairs, *Fertility Counseling and Treatment for Certain Veterans and Spouses*, 82 Fed. Reg. 6273 (Jan. 19, 2017).
12 U.S. Department of Veterans Affairs, *Enrollment – Provision of Hospital and Outpatient Care to Veterans*, 64 Fed. Reg. 54217 (Oct. 6, 1999).
13 See Pub. L. 98–525, title XIV, § 1401(e)(5)(A) (1984); Pub. L. No. 99-591, tit. II, § 209, 100 Stat. 3341, 3341-56 (1986); and 25 U.S.C. § 1676.
14 Pub. L. 111-148, §2713.

ineligible for IVF through VA, presenting yet another gap in veterans' access to reproductive healthcare. One in eight couples will experience infertility.[15] [16] In about one-third of infertility cases, clinicians are unable to diagnose the cause of the infertility.[17] For the other two-thirds of cases with male or female factor infertility, it is difficult to connect conditions such as endometriosis or low sperm count to military service.[18] Furthermore, even if veterans successfully obtain a VA service connection for their infertility, the Department's current authority to furnish IVF is limited to straight, married couples who can produce their own eggs and sperm and have an intact uterus. Veterans who wish to adopt existing embryos or need to use donated sperm or eggs are prohibited from doing so under VA's current authority. This denies LGBTQ veterans, single veterans, and veterans without their own sperm, eggs, or uterus the ability to have families using their earned VA healthcare benefits.

VA's New Reproductive Healthcare Interim Final Rule

On September 9, 2022, VA published an IFR that immediately allowed the Department to offer abortion counseling and provide abortions when the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term or when the pregnancy is the result of rape or incest.[19] The IFR also extends access to this care to beneficiaries enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

In accordance with the Administrative Procedure Act, VA concluded that ordinary notice and comment procedures would be impracticable and contrary to the public interest and there was good cause to issue this IFR with an immediate effective date. The Department allowed for a 30-day post-issuance public comment period, which ended on October 11, 2022. There were nearly 64,000 comments submitted, which VA is still in the process of analyzing to determine whether to issue a final rule to incorporate any changes in response to the public comments. In the meantime, the Department has begun the process of implementing the IFR.

Pregnancy Risks for Veterans

In explaining its rationale for issuing its September 9, 2022 IFR, VA cited at least 24 individual journal articles, clinical consensus documents, and practice bulletins published by academic researchers and national medical societies. These sources provide ample evidence about pregnancy risks and adverse outcomes, increasing maternal mortality rates in the United States, and the effects of reduced access to family planning and reproductive health services caused by clinic closures and state-level legislation restricting abortions. The dangers of pregnancy, and the need for abortion care to prevent harm to one's physical or mental well-being, cannot be understated.

Among developed countries, the United States has the highest rate of death among women who are pregnant or have given birth within the past three months.[20] For every patient who dies, a dozen more come

15 Barb Collura, CEO, RESOLVE: The National Infertility Association before the House Committee on Veterans' Affairs, Subcommittee on Health, Legislative Hearing, 117th Cong. (June 22, 2022).

16 American Society for Reproductive Medicine. (2012). Optimizing natural fertility. Retrieved May 31, 2016

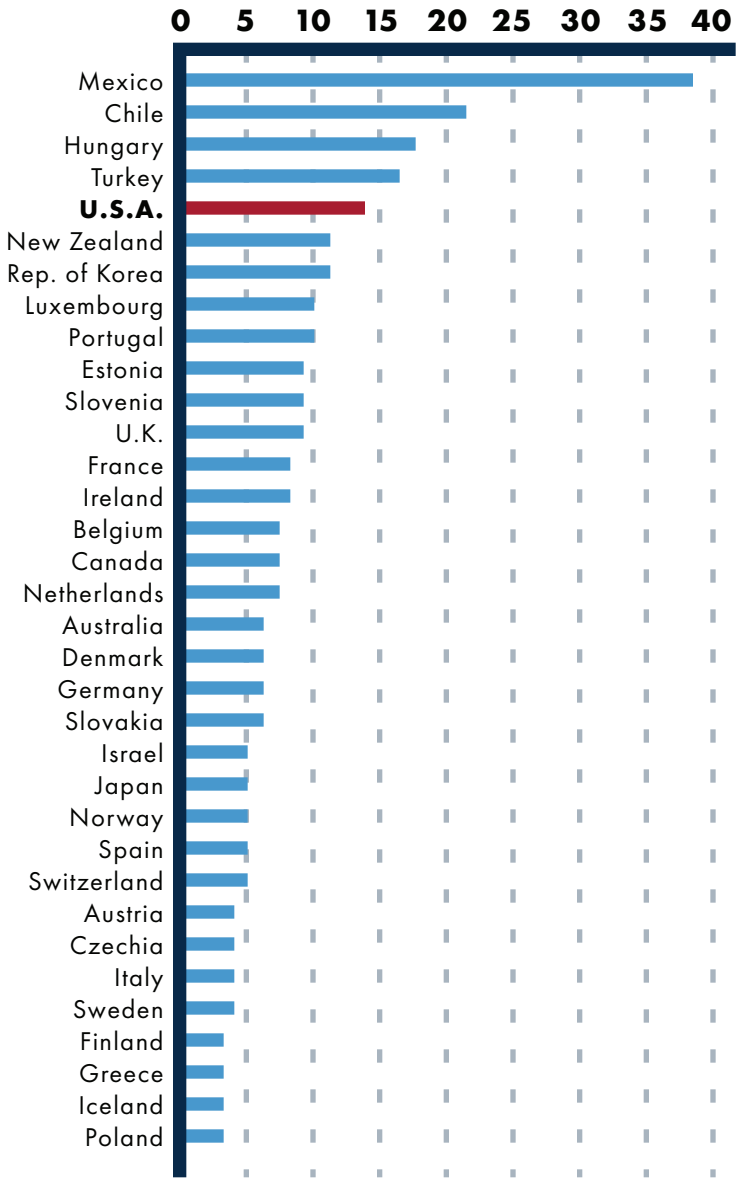
17 Chandra, A., Copen, C.E., & Stephen, E.H. (2013). Infertility and Impaired Fecundity in the United States, 1982-2010: Data From the National Survey of Family Growth. National Health Statistics Reports, 67, 1-19. Retrieved (February 7, 2018)

18 Dr. Ginny Ryan before the House Committee on Veterans' Affairs, Hearing on Examining Women Veterans' Access to the Full Spectrum of Medical Care, Including Reproductive Healthcare, Thorough the Department of Veterans Affairs (VA) Veterans Health Administration (VHA), 117th Cong. (September 15, 2022).

19 87 FR 55287 (Sept. 9, 2022).

20 Eugene Declercq and Laurie Zephyrin, Maternal Mortality in the United States: A Primer, Commonwealth Fund (Washington, D.C.: Dec. 2020).

Maternal deaths due to pregnancy or labor complications per 100,000 live births, OECD countries (Source: World Health Organization)



close, or endure lingering complications for years.[21] Women with gestational diabetes, pre-eclampsia and preterm delivery have higher risks of heart disease, diabetes, and stroke.[22] The diminished availability of prenatal care, particularly in rural areas, puts women veterans in as challenging a position as their civilian counterparts.[23] Accessing high-quality, timely healthcare while pregnant is not always an option. Complications go unaddressed and fetal anomalies go undiagnosed. Many patients must travel long distances to receive proper prenatal care or give birth. Treatment for complex health conditions such as heart disease[24], cancer[25], or bipolar disorder[26] presents additional risks to women as the treatments for such conditions often have teratogenic effects on an embryo. Without access to abortion care women may be forced to cease their own healthcare treatments in order to sustain a pregnancy.

Women veterans experience pregnancy complications at a much higher rate than their civilian counterparts due to factors such as hypertension, mental health conditions, age, and race.[27] VA's own research has found that among veterans for whom the Department covered pregnancy care between 2010 and 2019:

21 M. Huber, E. Malers, & K. Tunón, "Pelvic Floor Dysfunction One Year After First Childbirth in Relation to Perineal Tear Severity," *Scientific Reports*, no. 11, 12560, (2021); K.L. Alcorn et al., "A Prospective Longitudinal Study of the Prevalence of Post-Traumatic Stress Disorder Resulting From Childbirth Events," *Psychological Medicine*, 40, 1849-59 (Nov. 2010); Janis M. Miller and Lisa Kane Low, "Evaluating Maternal Recovery from Labor and Delivery: Bone and Levator Ani Injuries," *American Journal of Obstetrics and Gynecology*, 213(2) (Aug. 2015).

22 M.C. Gongora and N.K. Wenger, "Cardiovascular Complications of Pregnancy," *International Journal of Molecular Sciences* (Oct. 2015).

23 *America's increasingly atrocious access to maternity care, explained in 3 charts*, Vox (October 13, 2002) (https://www.vox.com/policy-and-politics/2022/10/1323400901/maternity-care-deserts-march-of-dimes-2022-report)

24 Darlington AM, Fleisher JD, Briller JE. *Peripartum Cardiomyopathy: Management Strategies for Pregnancy Termination.* Womens Health Reports, 2020 October

25 Esposito S, Tenconi R, Preti V, Groppali E, Principi N. *Chemotherapy against cancer during pregnancy: A systematic review on neonatal outcomes.* National Library of Medicine, 2016 September

26 Giles JJ, Bannigan JG. *Teratogenic and developmental effects of lithium.* Current Pharmaceutical Design, 2006

27 Examining Women Veterans' Access to the Full Spectrum of Medical Care, Including Reproductive Healthcare, Through the Department of Veterans Affairs (VA) Veterans Health Administration (VHA), 117th Congress, (2022) (Dr. Shereef Elnahal, Under Secretary for Health, Veterans Health Administration).

> *[T]he pregnancy-associated mortality ratio among [v]eterans using VA maternity care was* **67.9 per 100,000 live births.** *This ratio is significantly higher than reports from a semi-national analysis at 42.3 per 100,000 live births in the general population. Over half of the pregnancy-associated deaths occurred in the late postpartum period, and* **nearly 60% of pregnancy-associated deaths [among veterans] were related to suicide, homicide, or overdose. Overall, mental health conditions affected 78% of pregnancies among [v]eterans who died in pregnancy-associated events.**[28]

Federal Supremacy and the Delivery Abortion Services to Veterans

Questions have arisen about how state laws banning or restricting abortion will affect VA providers and veterans who receive care at VA medical facilities—including the extent to which VA patients or providers could be subject to criminal prosecution or civil liability. Some stakeholders, incorrectly assuming that state law cannot be enforced on any "federal property," have speculated about whether VA could operate abortion clinics to serve both veterans and non-veterans. Answers to questions like these are complex. Determining whether VA employees or patients might face criminal prosecution or civil liability depends primarily on two factors:

1. The degree of jurisdiction exercised by the state over the VA facility where the abortion occurred, and

2. Whether the individual concerned is a federal employee acting within the scope of his or her employment.

Federal laws like the Constitution's Supremacy Clause and Enclave Clause, along with the Assimilative Crimes Act, affect the degree to which state laws may be enforced at VA medical facilities. The fact that certain land or a given building is controlled by the federal government does not mean the state lacks any jurisdiction over it. Jurisdictional status depends on the circumstances under which the federal government originally obtained the property and any subsequent agreements with the state regarding transferring or ceding jurisdiction. In VA facilities under *exclusive* federal jurisdiction, state criminal and civil laws generally do not apply unless incorporated into federal law under the Assimilative Crimes Act. In locations where federal and state jurisdiction overlap, the property is under the concurrent, partial, or proprietorial jurisdiction of the federal and state governments, and state abortion laws could potentially be enforced. For facilities with *concurrent, partial,* or *proprietorial* jurisdiction, VA Police departments establish memoranda of understanding (MOU) with local law enforcement entities, outlining working relationships and interagency coordination responsibilities concerning law enforcement, emergency

The fact that certain land or a given building is controlled by the federal government does not mean the state lacks any jurisdiction over it.

28 Id.

response, requests for assistance, physical security, and access to VA property. At the time of this writing, the Committee was unable to identify any VA Police MOU that have specifically addressed enforcement of state abortion laws.

On the other hand, the courts have held that federal employees acting within the scope of their employment are generally immune from state criminal and civil liability.[29] VA regulations explicitly preempt state laws, rules, regulations, or requirements that conflict with VA clinicians' ability to "provide the same complete health care and hospital service to beneficiaries in all states."[30] VA reiterated this policy in its September 9, 2022, IFR on reproductive healthcare. In addition, in a June 24, 2022, statement, Attorney General Merrick Garland opined that federal employees performing abortions in the scope of their federal employment would not violate the Assimilative Crimes Act.[31] The Department of Justice's Office of Legal Counsel also issued an opinion on September 21, 2022, affirming the protections afforded to VA providers who provide abortions in states where it is now illegal.[32] "The rule is a lawful exercise of VA's authority," the opinion says.[33] It goes on to note, "states may not restrict VA and its employees acting within the scope of their federal authority from providing abortion services as authorized by federal law, including VA's rule."[34]

COMMITTEE OVERSIGHT VISITS

Between August 8, 2022, and September 8, 2022, Committee Chairman Mark Takano and Subcommittee on Health Chairwoman Julia Brownley conducted a series of oversight visits to six VA medical facilities in Texas, Oklahoma, Arizona, and Nevada. The overarching purpose of these visits was to provide Committee Members and staff a better understanding of the lived experiences of servicemembers and veterans and the challenges they have faced to access safe, timely, and lifesaving reproductive healthcare. Following is the list of VA medical facilities the Committee visited:

- VA Oklahoma City Health Care System (Oklahoma City, Oklahoma) – August 8, 2022
- VA North Texas Health Care System (Dallas, Texas) – August 9, 2022
- VA Central Texas Health Care System (Temple, Texas) – August 10, 2022
- VA Houston Health Care System (Houston, Texas) – August 11, 2022
- VA Southern Nevada Health Care System (Las Vegas, Nevada) – September 6, 2022
- VA Phoenix Health Care System (Phoenix, Arizona) – September 8, 2022

The Committee selected these six VA medical facilities because they are located in four states where patients' access to abortion varies. In addition, the number of women veterans served by each of these facilities is growing rapidly. Oklahoma[35] and Texas[36] have enacted near-total bans and are imposing

29 Memorandum from CRS Staff to Democratic Staff of the House Committee on Veterans' Affairs, *"Using Department of Veterans Affairs Facilities to Provide Abortion Services"* (Jul 1, 2022)
30 38 C.F.R. § 17.419(c).
31 U.S. Department of Justice, Press Release – Attorney General Merrick B. Garland Statement on Supreme Court Ruling in Dobbs v. Jackson Women's Health Organization (June 24, 2022), https://www.justice.gov/opa/pr/attorney-general-merrick-b-garland-statement-supreme-court-ruling-dobbs-v-jackson-women-s.
32 U.S. Department of Justice, Office of Legal Counsel, Intergovernmental Immunity for the Department of Veterans Affairs and its Employees When Providing Certain Abortion Services, 46 Op. O.L.C. (Washington, D.C.: Sept. 21, 2022).
33 Id.
34 Id.
35 Oklahoma House Bill 4327 signed into law May 26, 2022
36 Texas Senate Bill No. 8

civil and criminal penalties for abortion providers and patients.[37] [38] In Arizona, a state court has temporarily blocked enforcement of an 1864 law,[39] but a separate ban on abortions after 15 weeks of pregnancy is in effect. In Nevada, state law protects abortion, but state funds cannot be used to cover the cost of most abortions.[40]

In August, Chairwoman Brownley was joined by Representative Colin Allred, a fellow Member of the Committee on Veterans' Affairs, on her visit to the VA North Texas Health Care System. She was later joined by Representative Sylvia Garcia at the VA Houston Health Care System. In September, Chairman Takano was joined by Representative Susie Lee on his visit to the VA Southern Nevada Health Care System and by Representative Ruben Gallego (also a Member of the Committee on Veterans' Affairs) and Representative Greg Stanton at the VA Phoenix Health Care System.

At each VA medical facility, Chairman Takano, Chairwoman Brownley, additional House Members, and Committee staff met with the following officials and VA employees:

Executive Leadership Team (including Directors, Associate Directors, Chiefs of Staff, Associate Directors for Patient Care Services, and Assistant Directors). These officials are responsible for ensuring the implementation of VA policy, appropriately resourcing clinical care, and overseeing clinical operations at their respective facilities.

VA Police Chiefs. These law enforcement professionals will play a key role in protecting the physical safety of patients and VA employees should threats arise in response to the Department's new IFR on reproductive healthcare. They also may need to interact with state or local law enforcement seeking to prosecute crimes or enforce civil penalties related to abortion.

Women Veterans Program Managers, Clinical Directors of Women's Health, Maternity Care Coordinators, and Office of Integrated Veteran Care staff who are responsible for coordinating care with non-VA providers. These employees are most directly responsible for delivering reproductive healthcare to women veterans, and they will be on the front lines assisting patients in accessing the abortion care now authorized by VA's IFR.

Directors of Pharmacy. These employees help ensure that patients can access contraceptive medication, and they will be key players in facilitating medication abortions in accordance with the Food and Drug Administration's Risk Evaluation and Mitigation Strategy for dispensing drugs used for abortion.

Employee Union Leaders. Unions will help ensure employees receive sufficient guidance from VA central office and local management about employees' roles in delivering reproductive healthcare to veterans, including abortions, and the extent to which they can use medical leave if they need to travel to obtain an abortion for themselves or to accompany a family member. They will also help employees exercise their right to seek reasonable accommodations if they have moral or religious objections to being involved in providing abortion care.

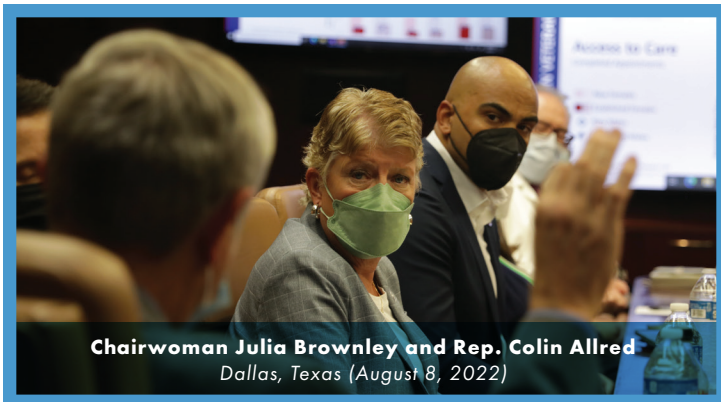
37 Oklahoma Statutes Title 21 §21-862
38 Texas Attorney General, Updated Advisory, July 27, 2022
39 Arizona Revised Statues, 13-3603
40 Nevada Revised Statues, Ch 442, Sec 250

Based on visits to the six VA medical centers, the Committee identified the following findings:

- **The facilities that appeared to be most ready to implement VA's new IFR on reproductive healthcare have strong, capable, forward-looking executive leaders who are skilled at empowering their staff and creative at using even limited resources to serve women veterans.** Interest and eagerness to engage in efforts to help veterans access abortion varied across executive leadership teams at the six VA medical facilities. Successful delivery of abortion services to veterans will require more consistent and sustained leadership commitment and support at VA facilities nationwide.

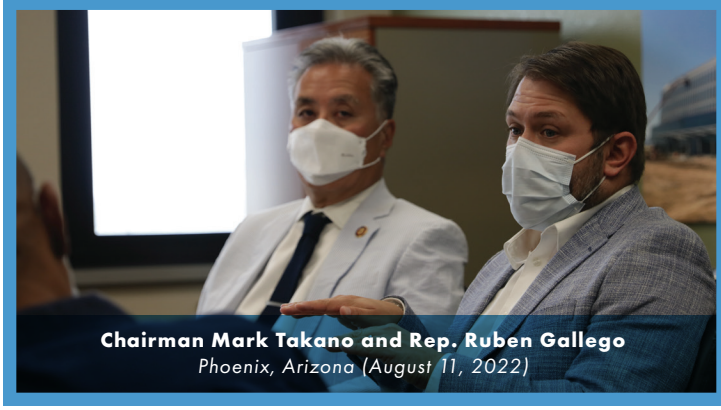
- **Nearly every VA women's health provider, women veterans program manager, and maternity care coordinator welcomed the idea of VA providing abortion and abortion counseling.** A VA provider in Las Vegas welcomed VA's decision to lift the gag order on discussing abortion with pregnant patients and was happy they would no longer have to refer veterans to community providers, saying, *"I recently treated a pregnant veteran with a serious mental illness who takes numerous teratogenic medications. [Before the Secretary's new rule] all I could do was refer her to community care and hope for the best."*

- **Some VA employees were under-informed or unable to directly address the Committee's questions about abortion care.** The Committee found that certain employees—even senior leaders like Chiefs of Staff and attorneys from the regional Office of General Counsel—did not always have command of well-established policies like VA's maternity care directive or the VA regulation that banned abortions and abortion counseling prior to September 9, 2022. At every medical facility they visited, Chairman Takano, Chairwoman Brownley, and Committee staff found themselves in the position of educating VA employees about existing statute, VA regulations and directives, and law enforcement jurisdictional issues. This pointed to a need for detailed guidance and training related to implementing VA's new IFR on reproductive healthcare.

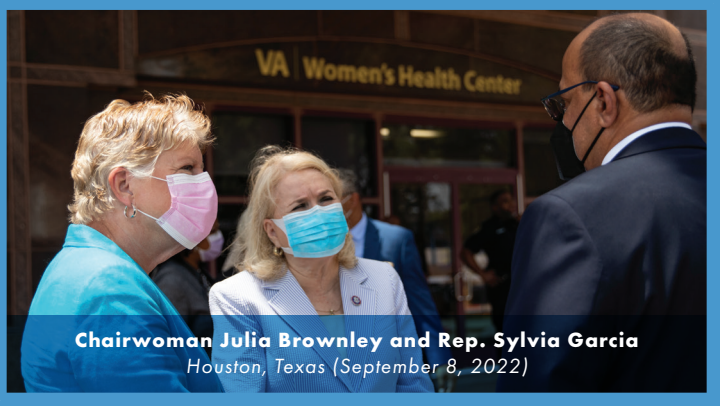


Chairwoman Julia Brownley and Rep. Colin Allred
Dallas, Texas (August 8, 2022)

Chairman Mark Takano and Rep. Susie Lee
Las Vegas, Nevada (August 10, 2022)



Chairman Mark Takano and Rep. Ruben Gallego
Phoenix, Arizona (August 11, 2022)



Chairwoman Julia Brownley and Rep. Sylvia Garcia
Houston, Texas (September 8, 2022)

- **Most VA executive leaders and women's health clinical staff agreed that more detailed, state-specific guidance from VA Central Office would be invaluable as they help women veterans navigate a myriad of pregnancy-related complications and access abortions in the post-*Dobbs* legal landscape.** The more capable and knowledgeable executive leadership teams and women's healthcare providers were especially frustrated about the lack of guidance for the field, which hindered planning for how they would help women veterans navigate reproductive healthcare in a post-*Dobbs* world. This was especially true at facilities in Oklahoma, Texas, and Arizona, where access to abortion outside VA has been eliminated or significantly restricted. Clinical employees in these locations expressed concerns and fear about whether they would be protected from adverse licensure actions or defended by VA in civil or criminal lawsuits related to providing reproductive healthcare services to veterans. An executive leader at a facility in Texas told Chairwoman Brownley and Committee staff, *"the questions you are asking us about how women veterans in our state will access lifesaving care are keeping us up at night....we are in a reactive position until something comes along, and I don't like being there."*

- **None of the VA medical facilities the Committee visited had exclusive federal law enforcement jurisdiction, and it remains to be seen how this status will come into play in states that have enacted criminal laws or civil penalties related to abortion.** VA Police Chiefs were clear at each location that with a legal arrest warrant, state and local law enforcement officers would have to be allowed on VA property and could potentially take employees, veterans, or visitors into custody. VA Police at each of the facilities said that in addition to any policies contained in formal MOUs , they would rely on relationships with outside police departments to guide how access to the VA campus would be handled. VA Police Chiefs believed that based on past experience it is unlikely that local law enforcement officers would show up unannounced to make arrests. However, because federal supremacy concepts have not yet been tested with regards to VA healthcare policies, none of the VA medical facilities were aware of the extent to which they could prevent employees from being targeted by local or state authorities seeking to enforce state laws, even if VA employees were involved in providing abortions within the scope of their federal employment.

- **Union leaders lacked information about employees' roles in delivering reproductive healthcare to veterans, including abortions, and the process by which employees with moral or religious objections can seek reasonable accommodation to be moved into roles that do not involve providing abortion care.** At the time of the Committee's visits, union leaders said they had not received specific guidance from VA management or their union about navigating these issues.

- **Based on conversations with Women Veteran Program Managers and Maternity Care Coordinators about maternity care data VA currently tracks, the Committee concluded the Department lacks sufficient data for monitoring potential demand for abortion services among veterans who use VA healthcare.** As of the summer of 2022, the only adverse pregnancy outcomes VA actively tracked were miscarriages, stillbirths, and "pregnancy losses," but it did not separately track abortions. The "pregnancy losses" category could overlap with the other categories, depending on who is asking or answering the question. This limits the usefulness of VA data for the purpose of projecting potential demand for abortion services among veterans.

VETERAN LISTENING SESSIONS

In conjunction with its site visits in August and September 2022, the Committee convened seven veteran listening sessions to gather information about veterans' past experiences accessing reproductive healthcare services at VA. Listening sessions were held in Del City, Oklahoma; Dallas, Texas; Austin, Texas; Houston, Texas; Las Vegas, Nevada; near Gallup, New Mexico; and Phoenix, Arizona. Representative Lloyd Doggett participated in the Austin, Texas, listening session with Chairwoman Brownley, and Representative Susie Lee participated in the Las Vegas, Nevada, listening session with Chairman Takano.

The listening sessions were not held on VA property, and the Committee did not involve VA in recruiting participants for the listening sessions. The sessions drew veteran women with a variety of experiences with VA, including current users, former users, and veterans who have never used VA healthcare. At some listening sessions, active duty servicemembers and non-VA women's health providers participated.

The following is a summary of the feedback the Committee received at the listening sessions about women veterans' experiences with VA healthcare services, broadly:

- Veteran women consistently described general, widespread concerns with being seen, heard, and treated appropriately in VA medical facilities. Their healthcare concerns included reproductive care and went far beyond it. The ongoing lack of basic parity between VA healthcare for men and women veterans is clear.

- Most of the women at the listening sessions had used a combination of VA and community providers for their healthcare and expressed many of the common frustrations with care coordination that the Committee regularly hears from veterans.

- Women veterans also expressed specific concerns with harassment from other (usually male) veterans in VA medical facility spaces that either aren't gender-specific or well-patrolled by VA staff or VA Police, and there was wide support among listening session participants for more gender-specific treatment options and physical access points at VA medical facilities.

When asked for their views about VA's longstanding prohibition on abortion and abortion counseling and whether VA should provide abortion care to veterans in light of the *Dobbs* decision, listening session participants had this to say:

> ***We can't wait another 25 years for this to course correct. We need VA to take care of this now.***
> – a veteran in Oklahoma

> ***As a survivor of military sexual trauma, I feel betrayed by my country and its leadership, and I can only imagine the feelings of other women who have had similar experiences… Abortion is not a dichotomous, reductionist argument of pro-life or pro-choice – it is healthcare. Please help us ensure that we have the healthcare we as women, servicemembers, and veterans need and deserve.***
> – a veteran in Dallas

> ***I'm done with being disrespected as a veteran and as a Black woman. I was willing to die for this country…. It's time [for VA] to get on the bandwagon or get out of the way.***
> – a veteran in Las Vegas

> ***Working women don't have time to navigate bureaucracy. We need full access to reproductive healthcare at VA.***
> – a veteran in Dallas

> ***It's against my Hippocratic Oath to not even be able to discuss options with my patients.***
> – a community provider in Oklahoma

COMMITTEE OVERSIGHT HEARING

On September 15, 2022, the Committee held an oversight hearing to examine women veterans' access to the full spectrum of medical care, including reproductive healthcare, at VA medical facilities. The Committee sought to address women veterans' access to primary care, mammography, contraception, prenatal care, maternity care, infertility treatment, care for pregnancy complications, abortion care, and peri- and post-menopausal care. VA disproportionately relies on community providers to furnish medical care to women veterans, and the Committee is concerned that this is leading to inequities in healthcare access for male and female veterans—particularly, for women veterans residing in rural areas. In addition, the Committee is concerned about the extent to which VA is achieving the goal of ensuring a safe, welcoming environment of care within its medical facilities for women veterans and LGBTQ+ veterans.

The hearing featured two panels of witnesses. The fist panel was comprised of the following witnesses from VA while the second panel featured a reproductive healthcare physician and two veterans who have experience with reproductive healthcare at VA:

PANEL 1

Dr. Shereef Elnahal
Under Secretary for Health
Veterans Health Administration
U.S. Department of Veterans Affairs

Accompanied by:

Dr. Patricia Hayes
Chief Officer, Women's Health
Veterans Health Administration
U.S. Department of Veterans Affairs

Dr. Amanda Johnson
Director, Women's Reproductive Health
Veterans Health Administration
U.S. Department of Veterans Affairs

Dr. Julianne Flynn
Acting Assistant Under Secretary for Health for Community Care
Veterans Health Administration
U.S. Department of Veterans Affairs

PANEL 2

Dr. Ginny Ryan
Professor and Division Chief, Reproductive Endocrinology and Infertility
University of Washington Medical Center Montlake

Lindsay Church
U.S. Navy Veteran

Kayla M. Williams
Senior Policy Researcher
RAND Corporation

In his opening statement, Chairman Takano emphasized the need for the IFR – which was issued six days prior to the hearing – noting that it worked to address inequalities in the system, both between VA and other federal healthcare programs, and between men and women who receive care at VA.[41]

41 House Committee on Veterans' Affairs, Hearing on *Examining Women Veterans' Access to the Full Spectrum of Medical Care, Including Reproductive Healthcare, Through the Department of Veterans Affairs (VA) Veterans Health Administration (VHA)*, 117th Cong. (September 15, 2022).

The rule change will save women's lives by allowing VA to provide healthcare services that states and communities are unwilling or unable to do.

Chairman Takano referenced a survey fielded by the Committee in August and September 2022, to hear from veterans across the country about their experiences receiving reproductive healthcare, contraceptive care, and infertility treatment at VA. As of September 12, 2022, the Committee had received more than 450 responses from veterans, the overwhelming majority of whom supported VA providing abortion counseling and abortion care, in circumstances like those covered by VA's new IFR on reproductive healthcare. Ninety percent of survey respondents said VA should provide abortion counseling, and 73 percent of survey respondents said VA should "always" or "sometimes" provide abortion care.[42]

The stark divide between the Democratic and Republican Members of the Committee on whether women veterans should be able to receive comprehensive reproductive care was further highlighted at the hearing. The Ranking Member, Mike Bost (R-IL) argued VA cannot enforce this rule on either legal or moral grounds. In his opening statement, the Ranking Member noted his "outrage" at VA's decision and indicated he and colleagues were already "considering sanctions against the VA for violating the anti-deficiency act."[43] He ended his comments by remarking, "Abortion is not healthcare."[44]

During their questioning of witnesses on both panels, other Republican Members insisted abortion care is never medically necessary while at the same time espousing their deep care for pregnant veterans. In one such exchange, one Republican while speaking with a second panel witness noted, "Not a single Republican here opposes care for mothers whose lives, unfortunately, are threatened, but all of us oppose abortion. Conflating the two is irresponsible fear-mongering."[45]

One in four of all known pregnancies will result in a miscarriage. The standard treatments for which are abortion medications or procedures, such as dilation and curettage (D&C), the formal name for removing tissue from a uterus. Instead of recognizing the critical nature of these life-saving procedures, Republicans were quick to point to the need for, "more conversations about support for crisis pregnancy centers and adoption services and those types of things."[46] Such "support" is not appropriate medical care for miscarriage management. Preventing the use of standards of care like medication management and surgical intervention will have disabling if not lethal consequences for women. Poorly managed miscarriages can cause infections that may result in sepsis or hemorrhage that can lead to death. No veteran should be denied access to medically managed miscarriage care and risk such an outcome because the treatments mirror that of abortion care.

Republican Members insisted veterans' lives have not and would not be endangered by preserving the agency's abortion ban. They assumed that if a veteran's life is at risk, VA providers will be able to save them. That is not the lived experience of VA providers that Committee staff, Members of Congress, and advocates have spoken to. Prior to the IFR, VA providers were forced to beg for favors from providers in the community to procure lifesaving abortion care for veteran patients because they were not allowed to discuss with, let alone treat the patient if the treatment included abortion care. And because VA providers were barred from discussing abortion, they could not refer patients to community providers as they would for any other healthcare condition. These were informal arrangements, with services delivered for free by community providers. This is a point Dr. Elnahal, emphasized in his testimony

42 Id.
43 Id.
44 Id.
45 Id.
46 Id.

to the Committee noting, "between 10 to 20 cases of veterans a year that our Office of Women's Health has told me about, we have actually had to send our veterans for life-saving care to community facilities."[47]

This coordination process could take hours, if not days, especially in states where clinicians fear scrutiny from licensing boards and penalties from law enforcement for interfering with a pregnancy. VA must have the authority to provide the whole spectrum of care a veteran may need before their life is endangered. Veterans should not be forced to risk infection, disability, or traumatic complication before the threshold of "life-threatening" is met. To tie the hands of medical providers from serving their veteran patients has no medical purpose.

VA has provided infertility care, including access to IVF since 2016, to certain veterans who meet narrow eligibility standards. The most narrow of these standards requires a veteran's infertility be the result of their service. Such a connection is incredibly difficult to prove given the nature of the condition of infertility. As a result, only 700 veterans in five years have been referred for IVF care. Removal of arbitrary eligibility standards and inclusion of infertility care in the full scope of healthcare remains an outstanding action item on the part of Congress. Veterans must have access to these services through VA, especially as states move to criminalize IVF. In her testimony, Dr. Ginny Ryan, a VA clinician in Washington state, described the toll that the current eligibility criteria take on patients and physicians:

> *"We are just beginning to understand all elements of military service that may predispose our veterans to higher rates of infertility. It is becoming increasingly frustrating and concerning that the veterans I see suffering from this infertility are rarely receiving the seamless, comprehensive reproductive healthcare they need and deserve. I can find examples every week of patients exhausted and discouraged by structural issues and unfair rules that exacerbate disparities and inequities."*[48]

These disparities and inequities vary from veteran to veteran, but many result from an inability to prove a service-connection, a lack of usable sperm, eggs or uterus, or they are not married to an opposite sex spouse. Women of reproductive age make up the fastest growing subset of new VA users, many of whom are having to choose between the enormous out-of-pocket costs of IVF or forgoing the experience of having a family.

In their testimony, Lindsay Church, a U.S. Navy veteran, shared their story of fertility treatment, pregnancy, and loss, and what that loss meant as a veteran without clear access to healthcare:

> *"The moral injury of having served a country to protect a Constitution that no longer protected my family when we needed it most was absolutely devastating."*[49]

Providing access to the full array of reproductive services, including abortion counseling and abortion services, will vastly increase the options available to those who need it. Individuals who utilize healthcare through the VA "tend to be of lower socioeconomic status than veteran, non-VHA users," who may not be able to access care externally to VA.[50] As one witness described, even if veterans and their families can access out-of-pocket care, that "fragmented care can [often] lead to worse health outcomes."[51]

47 Id.
48 Id.
49 Id.
50 Id.
51 Id.

Throughout the hearing, multiple witnesses and Members noted the existing, long-standing challenges with reproductive care. The majority of women's care is sent to the community due to a lack of trained professionals able to serve the quickly growing community. Further, the caseloads for women's care coordinators at VA have become extremely heavy, making it difficult for women to reach their providers and schedule appointments in a timely manner. Additionally, verbal and physical harassment of women and gender minority veterans continues to be an impediment to healthcare access and positive patient health experiences. In the words of one witness on the second panel, "From mottos, to pronouns, to bathrooms, many fear using VA because it continues to be traumatizing. No one should have to endure what we do for healthcare."[52]

The implementation of the IFR across the United States is one that the Committee plans to monitor, protect, and intervene in where necessary. Reproductive healthcare access is crucial to creating a more equitable VA and will save women veterans' lives and health across the country. Decades of abortion restrictions have not only disregarded women veterans' service to our country by ignoring their needs but created significant health and financial burdens that compromise veterans' very well-being.

The September 2022 hearing further underscores that Republican Members of Congress are willing to negate the needs and voices of women veterans yet again by limiting access to reproductive care and silencing the conversations between women veterans and their medical providers. While this debate continues in the political arena, the real-life consequences for both women veterans and VA providers will be in the balance.

CONCLUSION AND RECOMMENDATIONS

The moral injury of having served a country to protect a Constitution that no longer potected my family when we needed it most was absolutely devastating.

– Lindsay Church

This Committee, under the leadership of Chairman Mark Takano, has long advocated for equity and equality for all veterans because we recognize Americans from all walks of life have fought and died for our freedom since this country's founding – women veterans included. But their rights have come under attack by those intent on eroding all American women's freedoms.

For decades, women who rely on VA for their reproductive healthcare have had to independently locate, coordinate, and finance abortion care outside of VA. As a result of *Dobbs*, navigating these healthcare decisions has become even more complicated as access to this lifesaving medical care outside of VA has rapidly diminished.

This Committee's reproductive healthcare oversight initiative has aimed to examine the effects of the *Dobbs* decision on veterans and the challenges they face in accessing reproductive healthcare. Years of oversight work on reproductive healthcare for veterans and most recently, our site visits and listening sessions have led us to identify critical opportunities within VA to improve the delivery of reproductive healthcare, and informed recommendations for future congressional action to expand and strengthen

52 Id.

veterans' access to reproductive healthcare.

Within VA, the Committee found that strong facility leadership was essential to successfully implementing the new IFR on reproductive healthcare. There was a consensus among women's health providers and staff focused on women's health that VA should fully provide abortion and abortion counseling to veterans. Unfortunately, some VA employees were under-informed about existing VA policies that could impact reproductive healthcare and there was a strong demand signal from executive leaders and women's health clinical staff that more detailed, state-specific guidance from VA Central Office would be invaluable for navigating the post-*Dobbs* landscape. Overlapping federal and state laws have resulted in an ambiguous array of law enforcement jurisdictional status that has left VA medical facilities uncertain of how employees or veterans might be targeted by local or state authorities seeking to enforce state laws. Union leadership lacks information about how employees might be impacted when delivering reproductive healthcare to veterans and how reasonable accommodations might be made when employees raise objections over providing that care. Finally, the Committee concluded that VA lacks sufficient data for monitoring ongoing and projecting future demand for abortion services.

The Committee's listening sessions revealed frustrations by women veterans with being seen, heard, and treated appropriately in VA facilities and the ongoing lack of basic parity between VA healthcare for men and women veterans. Specifically, these veterans expressed concerns over their reproductive care, challenges with care coordination when utilizing community providers, recurring harassment due to a lack of gender-specific areas in VA medical facilities. Women veterans often voiced their desire for increased gender-specific treatment options and physical access points at VA medical facilities. Overwhelmingly, veterans participating in these listening sessions expressed strong support for the provision of reproductive healthcare at VA and characterized the lack of such care at VA with words like "betrayed," and "disrespected," and phrases like "wait another 25 years for this to course correct." These sessions were filled with visceral, compelling, and unfiltered accounts of how women veterans have been left on their own to navigate their reproductive healthcare decisions. All veterans deserve to know about the benefits and services they have earned, without exception. We must ensure veterans who have served our country have every opportunity to be fully informed partners in their own healthcare decisions

In light of ongoing efforts of VA leaders and policymakers to expand and strengthen veterans' access to reproductive healthcare, the Majority Staff of the Committee is making the following recommendations.

Recommendations for the Department of Veterans Affairs

1. **VA should prioritize building capacity to deliver abortion care to veterans in states where abortion is banned or significantly restricted.** It is not realistic to expect every VA medical facility will be able to provide abortion services in-house in the near future, and VA will likely rely on community providers to furnish abortion care as often as possible in the near term. However, in many states, community providers no longer exist. VA facility leaders in these locations need to quickly assess their readiness to offer abortions (both medications and surgical procedures), rapidly identify resource needs, and work with the Department to secure additional resources where necessary.

2. **VA should disseminate detailed guidance for clinical employees involved in providing abortion care about their protections when acting within the scope of federal employment.** At the medical facilities the Committee visited in states with abortion bans or restrictions, clinical employees expressed concerns and fear about whether they would be subject to adverse licensure actions or defended by VA in civil or criminal lawsuits related to the provision of reproductive healthcare services to veterans. The Department should clearly communicate with

employees—including those who are indirectly involved in the delivery of abortion services—about the extent to which they will be shielded from licensure or law enforcement actions.

3. **VA's Office of General Counsel should compile a comprehensive inventory of the law enforcement jurisdictional status of each VA medical facility, applicable state abortion laws, and existing Memoranda of Understanding with state and local enforcement agencies.** Given the rapidly evolving legal landscape, the Department should proactively create a centralized repository of information that will help it prepare for any attempted enforcement of state criminal or civil penalties against VA patients, employees, or visitors.

4. **VA should develop training related to implementation of its new reproductive healthcare interim final rule that is specific to employees' roles.** Rather than developing one-size-fits-all training modules, VA should focus attention on developing clear guidance and training for key groups of employees who will be involved in furnishing abortion care, including executive leadership teams, clinical providers and nurses, pharmacy staff, women veterans program managers, maternity care coordinators, VA Police, and attorneys from regional offices of VA's Office of General Counsel.

5. **VA should collect better data on veterans' pregnancy histories and outcomes, including live births, miscarriages, preterm births, stillbirths, and abortions—for those receiving maternity care both inside and out of VA.** As of the summer of 2022, the only adverse pregnancy outcomes VA actively tracked were miscarriages, stillbirths, and "pregnancy losses," but it did not separately track abortions. The "pregnancy losses" category could overlap with the other categories, depending on who is asking or answering the question. Without specific, reliable data on maternal and fetal health, VA and policymakers will be unable to monitor veterans' experiences with pregnancy, identify patterns in demand for abortion services, or address potential inequities or disparities within the veteran population or between VA and non-VA patients.

Recommendations for Congressional Action

1. **Congress should codify VA's authority to furnish abortions.** The Secretary of Veterans Affairs already has the broad authority to determine what healthcare services veterans "need" and to update VA's medical benefits package accordingly. He was acting within that authority when he issued the new interim final rule to allow abortion counseling and furnish abortions when the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term, or when the pregnancy is the result of rape or incest. However, opponents of the rule continue to argue the Veterans Health Care Act of 1992 precluded VA from taking this action. By enacting legislation, Congress would remove any doubt that the Department has the authority to provide abortion care to veterans.
   - **Chairwoman Brownley's bill H.R. 345, the Reproductive Health Information for Veterans Act, would statutorily guarantee VA providers ability to discuss abortion care with veterans. Prior to the IFR, VA providers were under a strict regulatory gag rule not to discuss abortion with patients under any circumstances.**

2. **Congress should eliminate contraceptive co-pays for veterans.** Under existing statute, VA lacks the authority to do away with co-pays for individual pharmaceuticals. Congress should enact legislation to extinguish contraceptive co-pays for veterans and put them on par with beneficiaries of DOD and other federal healthcare programs, as well as those covered by commercial health insurance plans.
   - **Chairwoman Brownley's bill H.R. 239, the "Equal Access to Contraception for Veterans Act," would eliminate copays for contraception.**

3. **Congress should expand veterans' eligibility for in vitro fertilization.** VA's existing authority to cover in vitro fertilization is so limited only 600 veterans have accessed it since 2016. Infertility is a medical condition and should be treated the same way VA would treat any other medical condition. Congress should eliminate the current service connection requirement; expand eligibility to unmarried veterans, and LGBTQ+ veterans; and allow patients to use donated gametes or embryos.
    - **Chairwoman Brownley's bill, H.R. 1957, the "Veterans Infertility Treatment Act" would make infertility care part of healthcare at VA decoupling it from service connection. VA would be authorized to cover up to six completed cycles of IVF and would finally be able to do so using donated gametes or embryos for those patients who cannot provide their own. LGBTQ veterans, single veterans and unmarried veterans would have access to appropriate fertility care. Lastly, the bill would affirm that any veteran who struggles with infertility or is at risk of it due to a medical condition or treatment, is eligible for VA infertility care.**

As nationwide access to lifesaving medical care outside of VA becomes restricted and navigating healthcare decisions becomes more complicated, it is imperative that women veterans, like all veterans, have the opportunity to be fully informed partners in their own healthcare decisions. By expanding and strengthening veterans access to reproductive healthcare at VA, we can ensure these veterans are seen, heard, and treated with the respect they have earned and deserve. We also send a message to the women veterans, and girls who aspire to serve our country in the future, who are watching and listening that their service to our country is valued. Women veterans have fought for America's freedom, and they deserve that same freedom: freedom to choose, freedom to access comprehensive healthcare, and a right to privacy.