Congress of the United States
Washington, DC 20510

October 7, 2022

Michael P. Shores
Director
Office of Regulation Policy and Management
Office of General Counsel
U.S. Department of Veterans Affairs
810 Vermont Avenue NW, Room 1063B
Washington, DC 20420

Dear Mr. Shores:

On Friday, September 9, 2022, the U.S. Department of Veterans Affairs (VA) published an Interim Final Rule (IFR) that immediately allowed the Department to offer abortion counseling and perform 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. 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). Pregnancy, even under the best of circumstances, is a dangerous undertaking for women and can cause a host of long-term consequences. This is a long-overdue step in improving care for women veterans, and in furthering VA's ongoing efforts to build trust with women veterans, who for decades have had to independently find, coordinate, and finance life-saving medical care that should have been provided by VA. Women veterans have earned and deserve access to these comprehensive reproductive services no matter where they live. We strongly support this regulatory action because it is simply the right thing to do to ensure veterans who have served our country have the opportunity to be fully informed partners in their own healthcare decisions.

Prior to the U.S. Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision on June 24, 2022, veterans needing abortions could largely access care through providers in their local communities or in the surrounding area. That is no longer the case for many veterans. Certain states have begun to enforce abortion bans that create urgent risks to the lives and health of pregnant veterans and VA beneficiaries. Collectively, these states and others that have enacted significant abortion restrictions are home to at least 260,000 women veterans of childbearing age.[1] In the weeks between the overturning of *Roe v. Wade* and VA's published IFR, pregnant veterans facing complicated and dangerous pregnancies had no assistance from their states, communities, or VA. Rightfully, VA has taken action to expand its medical benefits package in light of veterans' diminishing access to life-saving care.

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[1]Kayla M. Williams, RAND Corporation, *Women Veterans' Access to Reproductive Health Care: Considering VA's New Interim Final Rule,* Testimony Presented Before the U.S. House of Representatives Committee on Veterans' Affairs, 117th Congress, 2nd sess., p. 2-3 (Washington, D.C.: September 15, 2022).

Statutory Basis for VA's Interim Final Rule

We strongly agree with VA's analysis that it has the statutory authority to promulgate this regulation under the Veterans' Health Care Eligibility Reform Act of 1996. The fact VA is promulgating this regulation now to provide abortion counseling and furnish abortion services does *not* mean VA previously lacked any statutory authority to do so. Indeed, VA has had such authority since 1996, but the Department is only now acting because of the urgent risks to the health and lives of veterans and CHAMPVA beneficiaries that have been created in the wake of the U.S. Supreme Court's recent decision.

As evidenced by a report issued 40 years ago by the agency now known as the U.S. Government Accountability Office, VA has provided healthcare to women veterans for decades.[2] 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.[3] However, that original authority excluded 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.[4] VA has since added pregnancy and delivery care to its medical benefits package, and veterans can also now receive certain infertility services at VA.[5] However, 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. These prohibitions were continued under the broad discretion afforded to the Secretary by the Veterans' Health Care Eligibility Reform Act of 1996—*not* because of the Veterans Health Care Act of 1992.

According to VA's new IFR, the Veterans' Health Care Eligibility Reform Act of 1996 "effectively overtook" the Veterans Health Care Act of 1992, the law that originally banned abortion. VA also states in its IFR that the 1996 law is the basis on which VA has been offering general pregnancy care and certain infertility services—both of which were prohibited under the 1992 law—along with pap smears, breast exams and mammography, and general reproductive health services. We concur with VA's analysis.

Furthermore, VA states in its IFR that, "Congress has ratified VA's interpretation that [the 1992 law] does not limit the medical care that the VA may provide pursuant to its authority under [the 1996 law]." VA's analysis is based on the fact that the Deborah Sampson Act of 2020 did not reference the 1992 law at all—it only referenced the medical benefits package VA established under the Veterans' Health Care Eligibility Reform Act of 1996. Additionally, VA also pointed out in its IFR that the Department is not subject to the Hyde Amendment or any other underlying statutory restrictions governing the provision of abortion care by other federal

[2]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).

[3]Pub. L. No. 102-585, § 106, 106 Stat. at 4947.

[4]Pub. L. No. 104-262, § 101, 110 Stat. at 3178.

[5]38 C.F.R. § 17.38(a).

agencies. Once again, we concur with this analysis.

Congress continues to further clarify its intent that veterans be fully informed about the spectrum of healthcare services available at VA. Recently, the House and Senate passed the Solid Start Act of 2021, which requires VA to make three phone calls to veterans during their first year of separation from the Armed Forces.[6] The bill contains a provision that requires VA to, "provid[e] women veterans with information that is tailored to their specific health care and benefit needs." During debate in the House, proponents of this measure made clear their intent that veterans deserve to know about all of the benefits and services they have earned—with no exceptions. It is worth noting that the Solid Start Act of 2021 passed unanimously in the Senate and with a greater than two-thirds majority in the House on September 29, 2022.

Opponents of this IFR have argued that congressional intent to supersede the Veterans Health Care Act of 1992 has been unclear. However, these opponents have yet to file any formal lawsuits that would allow their theory to be tested. It should also be noted that these opponents have thus far been selective in their argument that section 106 of the 1992 law still stands. A fuller analysis of their position reveals a deep inconsistency because the same section of the Veterans Health Care Act of 1992 also explicitly prohibits VA from providing pregnancy and infertility care – services VA does now offer under the fuller authority of the 1996 law. This demonstrates the impact of the 1996 law and the broad authority granted to the Secretary to develop VA's medical benefits package to include medical services the Secretary determines to be needed.

Evidence that Veterans Need Abortion Care at VA

In explaining its rationale for issuing this new regulation, VA's IFR cites 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. We are pleased to see VA cite such ample evidence in the IFR. The dangers of pregnancy, and the need for abortion care to prevent harm to one's physical or mental wellbeing, cannot be understated.

Under the gaps in care created by VA's previous regulatory environment, 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. Most worrisome of all were the pregnant veterans with life-threatening pregnancy complications who were turned away from care at VA. The IFR now allows VA to

[6]U.S. Congress, Senate, *Solid Start Act of 2021*, S. 1198, 117th Cong., 2nd sess., passed/agreed to in Senate and House, Sept. 29,2022.

remove blinders and gags from its providers so that it can ensure pregnant veterans receive the care they require. Properly treating veterans will no longer be dependent on the bravery of providers to uphold their Hippocratic oath, but a standard of care established by a healthcare system that sees women veterans as whole people, deserving of evidence-based treatment. Furthermore, it is simply the right thing to do to ensure veterans who have served our country have the opportunity to be fully informed partners in their own healthcare decisions.

Among developed countries, the United States has the highest rate of death among pregnant women and the first three months after birth.[7] For every one that dies, a dozen come close, or endure lingering complications for years.[8] Women with gestational diabetes, pre-eclampsia, and preterm delivery have higher risks of heart disease, diabetes, and stroke.[9] Veteran women are known to be at high risk for pregnancy complications due to factors such as hypertension, mental health conditions, age, and race.[10] Diminished availability of prenatal care, particularly in rural areas, puts women veterans in as challenging a position as their civilian counterparts. Enduring a pregnancy with high-quality, timely healthcare is not always an option. Complications go unaddressed and fetal anomalies go undiagnosed. Women must travel long distances to receive proper prenatal care or give birth. Women veterans with severe health conditions such as heart disease, cancer, or bipolar disorder cannot be forced to forgo treatment for their conditions to sustain a pregnancy.

We also know that women veterans experience pregnancy complications at a much higher rate than their civilian counterparts. According to testimony delivered at a September 15, 2022, U.S. House Committee on Veterans' Affairs hearing by VA's Under Secretary for Health, Dr. Shareef Elnahal, VA found that among veterans for whom the Department covered pregnancy care between 2010 and 2019:

> [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 were

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

[8]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).

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

[10]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. Shareef Elnahal, Under Secretary for Health, Veterans Health Administration).

> related to suicide, homicide, or overdose. Overall, mental health conditions affected 78% of pregnancies among Veterans who died in pregnancy-associated events.[11]

We applaud the Secretary for making the decision to prioritize the health and safety of veterans. Given the healthcare challenges faced by women in the United States, and the new legal landscape created in the wake of the U.S. Supreme Court's *Dobbs* decision, it is paramount that VA be better positioned to help mitigate the increased risk of pregnancy complications faced by veterans. It is not acceptable that veterans could die of preventable pregnancy complications or be forced to give birth after surviving a rape or incest. Given the choice between turning veterans away or serving them during an emergency, the right choice is *always* to serve them. This IFR will ensure that VA can finally do just that.

Equity Between Men and Women Veterans, Parity with Other Federal Health Care Programs

This rule will also promote better equity between the men and women who receive care at VA by removing the gag order on what doctors can discuss with their women patients. No such gag order has ever existed for providers caring for male veterans, and it is unacceptable that it should be exercised against women veterans who served alongside their brothers in arms and deserve full and equal access to care.

The IFR also states VA's belief that the Department should, "provide at least the same reproductive health care services that other Federal agencies provide their beneficiaries." This parity argument is one that we and advocates have made repeatedly in engagements with the Secretary. For decades, the Department of Defense, the Bureau of Prisons, and the Indian Health Service have had the authority to provide abortion care to beneficiaries in instances of rape, incest, and threat to life. We are pleased veterans will now have the same access to care as patients of other federal healthcare programs.

Rationale for Immediate Implementation

Ordinarily, the Administrative Procedure Act requires that federal agencies publish rules in the Federal Register and allow a 30-day delay before the rule becomes effective, but agencies can forego that 30-day notice if they find good cause that compliance would be "impracticable, unnecessary, or contrary to the public interest." The Secretary found there was good cause for immediate effectiveness in this instance because leaving veterans and CHAMPVA beneficiaries without access to abortions and abortion counseling puts their health and lives at risk. The IFR states, "it is, without exception, an urgent and tragic event when pregnant veterans and VA beneficiaries face pregnancy-related complications that put their health or lives at risk. In such cases, the veterans, VA beneficiaries, and their families must be confident their health care providers can take swift and decisive action to provide needed health care." We agree with this

[11]Ibid.

sense of urgency.

Assertion of Federal Supremacy

The IFR explicitly states, "VA clarifies that State and local laws and regulations that would prevent VA health care professionals from providing needed abortion-related care, as permitted by this rule, are preempted." Importantly, the IFR goes on further to note:

> This rulemaking serves as notice that all VA employees, including health care professionals who provide care and VA employees who facilitate that health care, such as VA employees in administrative positions that schedule abortion procedures and VA employees who provide transportation to the veteran or CHAMPVA beneficiary to the VA facility for reproductive health care, may not be held liable under State or local law or regulation for reasonably performing their federal duties.

The Department of Justice's Office of Legal Counsel issued an opinion on September 21, 2022, affirming the lawfulness of VA's IFR and the protections afforded to VA providers who provide abortions in states where it is now illegal.[12] "The rule is a lawful exercise of VA's authority," the opinion says. "Moreover, 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." It is critical that as a federal healthcare provider VA be able to provide appropriate care to veterans, free from interference from state and local laws that are in contravention to the healthcare needs of veterans.

Key Areas of Focus as VA Implements this Rule

In light of the rapid erosion of access to abortion care that is happening in the wake of the *Dobbs* decision, it is imperative that VA implement this rule as quickly as possible, at as many VA medical facilities as possible, so that veterans can access safe, timely abortion care.[13] To do so successfully, VA will need to focus on several areas, which were not fully addressed in the IFR. These include partnering with community care providers, covering travel expenses for veterans who cannot access abortion care locally, and rapidly deploying the resources necessary to deliver abortion care at VA medical facilities.

In states where abortion services are still available outside VA, individual VA medical facilities may opt to partner with community providers to furnish abortion services, rather than provide these services in-house. To do so, they may enter into local Veterans Care Agreements (VCA) with individual abortion providers, or the Department can direct the two third-party

[12]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).

[13]*The New York Times*, "Tracking the States Where Abortion is Now Banned," September 23, 2022. https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html (accessed September 27, 2022).

administrators of its regional community care networks to add abortion care providers to their networks, in accordance with the standards outlined in their contracts. It is not clear from the IFR whether VA intends to use only VCAs to furnish abortion services through community providers, or if the Department intends to establish VCAs only in the near-term, until the third-party administrators have built up sufficient networks of community providers. We urge VA to make its strategy clear to both its medical facility leaders and its third-party administrators. We also encourage VA to create a standardized written authorization for abortion services from community providers that can be utilized by referring providers at all VA medical facilities, in order to streamline the billing and care coordination process for abortion services delivered by community providers.

In locations where VA is not immediately able to provide needed care in-house, and in states where abortion is now banned or severely restricted, veterans will need to travel to other VA medical facilities or to VA-contracted community care providers in states where abortion is still legal. The IFR did not fully address the extent to which VA will cover travel expenses for veterans who need abortion care, or whether the Department will cover travel expenses for a non-veteran to accompany a VA patient for abortion care. While many veterans in need of abortion care are already eligible for VA's existing Beneficiary Travel Program—because they have VA disability ratings of 30 percent or greater, or because their income is below a certain threshold—it is reasonable to expect that some veterans who need to travel for abortions will not qualify for travel reimbursement under VA's existing rules. We encourage the Secretary to move quickly to issue clarifying guidance to the field about the extent to which VA's existing beneficiary travel authority may be utilized for these services and, if necessary, update its beneficiary travel regulations to ensure patients will not incur any expenses if they need to travel for this life-saving care.

While we understand that not all VA medical facilities will immediately have the necessary staff, equipment, or other resources to provide abortion services in-house and will thus need to partner with community providers where possible, we are concerned about wait times for abortion services outside VA in certain localities. For example, in Kansas, where Planned Parenthood Great Plains provides abortion services at three clinics, demand for care is so high due to abortion bans and severe restrictions in neighboring states that its clinics can only see about 10 to 15 percent of patients requesting appointments.[14] We therefore encourage the Secretary to make every effort possible to build internal capacity to give veterans the reproductive healthcare they need—everywhere, not just in states with abortion bans or restrictions. VA medical facilities must continue to adhere to existing credentialing and privileging policy requirements and ensure practitioners who provide abortions have completed any necessary training and education and been granted appropriate clinical privileges. In many instances, VA medical facilities will have to procure new medical equipment, such as ultrasound machines, or hire or train additional providers or radiology staff. If VA needs additional

[14]Lisa Gutierrez, "'Eye of the Storm': Planned Parenthood in Kansas Can't Keep Up with Abortion Demand," *Kansas City Star*, Sept. 26, 2022. https://www.kansascity.com/news/business/health-care/article265911316.html (accessed Sept. 28, 2022).

resources to build internal capacity to provide abortion care, the Secretary should let Congress know as soon as possible.

Conclusion

This IFR, and the provision of life-saving abortion care, represent an enormous step forward in VA's ongoing efforts to build trust with women veterans. For decades, these patients have had to find, coordinate, and finance life-saving medical care outside of VA; simply because past Administrations never took action to change VA's rules and offer the comprehensive reproductive healthcare services women veterans have earned and deserve. This rule will allow access to medically necessary and appropriate reproductive health services no matter where VA's patients live, and we strongly support its implementation. We appreciate your thoughtful review of our comment on this interim final rule.

Sincerely,

Mark Takano
Member of Congress
Chairman
House Committee on
Veterans' Affairs

Julia Brownley
Member of Congress
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