

CENTER *for* REPRODUCTIVE RIGHTS

Statement for the Record of the Center for Reproductive Rights

Hearing: "Beyond Deborah Sampson: Improving Healthcare for America's Women Veterans in the 117th Congress." U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health

March 18, 2021

Chairwoman Brownley, Ranking Member Bergman, and Members of the House Committee on Veterans' Affairs Subcommittee on Health:

The Center for Reproductive Rights respectfully submits the following testimony to the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health.

Since 1992, the Center for Reproductive Rights has used the power of law to advance reproductive rights as fundamental human rights that governments around the world are obligated to protect, respect, and fulfill. Reproductive freedom lies at the heart of the promise of human dignity, self-determination, and equality embodied in both the U.S. Constitution and the Universal Declaration of Human Rights. Our litigation and advocacy over the past 26 years have expanded access to reproductive health care around the nation and the world. We have played a key role in securing legal victories in the United States, Latin America, Sub-Saharan Africa, Asia, and Eastern Europe on issues including access to life-saving obstetrics care, contraception, safe abortion services, and comprehensive sexuality information. We envision a world where every person participates with dignity as an equal member of society, regardless of gender; where every person is free to decide whether or when to have children and whether or when to get married; where access to quality reproductive health care is guaranteed; and where every person can make these decisions free from coercion or discrimination.

We appreciate the Subcommittee's attention to the vital issue of women veterans' access to healthcare at the Department of Veterans Affairs (VA). Reproductive health care, including access to contraception, abortion, infertility care and maternal health services, is a fundamental health care need for an increasing number of veterans, as the demographic composition of the veteran population evolves. Women comprise approximately 10% of the total veteran community and are statistically the fastest growing cohort within that community.¹ Within that group, women of reproductive age between ages 18-44 are the fastest growing subset of new VA users.² In addition, research estimates that the veteran community includes more than 11,000 trans men.³ It is vital that the Department of Veterans Affairs is prepared to attend to all their health care needs.

¹ NAT'L CTR. FOR VETERANS ANALYSIS & STATISTICS, U.S. DEP'T OF VETERANS AFFAIRS, WOMEN VETERANS REPORT: THE PAST, PRESENT AND FUTURE OF WOMEN VETERANS 10 (2017), https://www.va.gov/vetdata/docs/SpecialReports/Women_Veterans_2015_Final.pdf.

² Sarah A. Friedman et al., *New Women Veterans in the VHA: A Longitudinal Profile*, 21 WOMEN'S HEALTH ISSUES 103, 103-11 (2011), <https://pubmed.ncbi.nlm.nih.gov/21724129/>.

³ Gary J. Gates & Jody L. Herman, *Transgender Military Service in the United States*, THE WILLIAMS INSTITUTE (2014), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Military-Service-US-May-2014.pdf>.

Nonetheless, veterans in need of reproductive health care consistently face unnecessary barriers and restrictions when attempting to access that care through the Veterans Health Administration (VHA). Challenges and restrictions exist in almost every facet of care, from bans on abortion services to inequitable restrictions on who can access assisted reproductive technologies. Despite their service to the United States, veterans are often forced to seek and pay out of their own pockets for additional private care outside of the VHA system, as a direct result of the numerous institutional, financial, and logistical barriers they face when trying to access reproductive health care. Veterans deserve full and equal access to the comprehensive range of health care they will need in the course of their reproductive life span, including access to high-quality contraceptive care, abortion services, assisted reproductive technology, and maternity care.

Access to health care, including reproductive health care, is a human right, and the United States government should honor our veterans by ensuring access to this basic care. Lack of adequate reproductive health services can have profound impacts, including financial insecurity, increased risk of intimate partner violence, and maternal and neonatal deaths.⁴ These impacts are disproportionately felt by marginalized communities in the U.S who have long faced systemic barriers to health care—including low-income people, rural populations, people of color, LGBTQI people, people with disabilities, and immigrants.⁵ Access to timely, comprehensive essential health care including contraception and abortion is even more urgent and necessary as the country continues to endure the COVID-19 public health and economic crises.⁶

I. Veterans face unnecessary barriers to contraception.

Contraception is an essential part of health care. Beyond allowing people to plan and space pregnancies, birth control can be used for a variety of non-contraceptive benefits, including management of medical conditions such as pre-menstrual dysphoric disorder, menstrual migraines and endometriosis.

Every year, VHA serves the contraceptive needs of approximately 24,000 female veterans.⁷ But unlike the millions of civilians insured under plans that comply with the Affordable Care Act, most veterans who access contraception through VHA must pay a copay for their contraception. This lack of parity is especially troubling when coupled with the fact that women veterans are more likely to live in poverty than male veterans. Similarly, transgender veterans are more likely to live in poverty than their cisgender counterparts. Even a small copay could be a prohibitive barrier to accessing contraception for those veterans.⁸ Studies show that the costs associated with contraception, even when small, lead women to forgo it completely, to choose less effective methods, or to use it inconsistently.⁹ Congress should act swiftly to pass the Equal Access to

⁴ CTR. FOR REPROD. RIGHTS & COLUMBIA MAILMAN SCH. OF PUB. HEALTH, HEILBRUNN DEP'T OF POPULATION & FAMILY HEALTH, ABORTION IS ESSENTIAL HEALTHCARE: ACCESS IS IMPERATIVE DURING COVID-19 1 (2020), <https://reproductiverights.org/sites/default/files/documents/USP-COVID-FS-Interactive-Update.pdf>.

⁵ *Id.*

⁶ *Id.*

⁷ Ariana Puzzo, *Yearlong Birth Control Supply for Female Vets Could Cut Costs and Unplanned Pregnancies*, MILITARY TIMES (July 11, 2019), <https://www.militarytimes.com/veterans/2019/07/11/yearlong-birth-control-supply-for-female-vets-could-cut-costs-and-unplanned-pregnancies/>.

⁸ GUTTMACHER INST., EVIDENCE YOU CAN USE: INSURANCE COVERAGE OF CONTRACEPTION (2020) <https://www.guttmacher.org/evidence-you-can-use/insurance-coverage-contraception#>.

⁹ See, e.g., GUTTMACHER INST., A REAL-TIME LOOK AT THE IMPACT OF THE RECESSION ON WOMEN'S FAMILY PLANNING AND PREGNANCY DECISIONS 5 (2009), <http://www.guttmacher.org/pubs/RecessionFP.pdf>.

Contraception for Veterans Act (H.R. 239), reintroduced to the House of Representatives in January of this year, which aims to eliminate copays on contraception for veterans, and should take additional action to eliminate copays for contraceptive counseling and services. These steps would align veterans' health benefits with those enjoyed by millions of civilians on ACA-compliant insurance plans.

Eliminating copays on contraception, especially in concert with other policy changes, could increase consistent use of oral contraceptives and prevent unintended pregnancies in the veteran population. For example, like most insurance systems in the country, the VA currently distributes three-month supplies of birth control pills, which must be refilled.¹⁰ However, VA data indicates that 43% of veterans who receive a three-month supply of oral contraceptives experience a gap of at least 7 days or more between contraceptive refills over the course of a year.¹¹ Such gaps leave veterans at risk of an unintended pregnancy. Recent research indicates that requiring the VA to dispense a 12-month supply of contraception could significantly reduce unintended pregnancy rates among veterans and improve adherence to contraceptive methods.¹²

II. The VA must eliminate the ban on abortion in the VA Medical Benefits Package.

Our Constitution protects the right of each of us to chart our own life path and to make the deeply personal decisions that impact our lives, our families, and our health, including whether and when to become a parent. One in four women in the United States will make the decision to have an abortion in the course of her life.¹³ Abortion is essential health care, a constitutional right, and a human right. And yet under existing VA regulations, VHA does not make abortion, or abortion counseling, available under any circumstances.¹⁴ This restriction is mirrored closely by regulations governing CHAMPVA, which prohibits abortion except to save the life of the pregnant person. As a result of these policies, veterans and their dependents either are denied care at VHA facilities, resulting in a delay in accessing care, or turn directly to private, out-of-network health care providers.

Abortion access is already at a precarious point in this country. The past decade has seen an escalating, coordinated attack on access to abortion care. Since 2011, more than 450 state laws restricting and banning abortion care have been enacted. These laws are designed to ensure that patients face often insurmountable financial and logistical barriers to care and clinics are forced to close.¹⁵ Six states—Kentucky, Mississippi, Missouri, North Dakota, South Dakota and West Virginia—have only one abortion clinic.¹⁶ Eighty-nine percent of counties in the United States do not have a single abortion clinic and some counties that have a clinic only provide abortion services on certain days of the week.¹⁷ In addition, many states require multiple, medically

¹⁰ Kathleen J. Davis, *Study: VA Could Prevent Hundreds of Unintended Pregnancies by Adjusting Birth Control Supplies*, 90.5 WESA (July 18, 2019), <https://www.wesa.fm/post/study-va-could-prevent-hundreds-unintended-pregnancies-adjusting-birth-control-supplies#stream/0>.

¹¹ *Id.*

¹² *Id.*

¹³ Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107(12) AM. J. PUB. HEALTH 1904, 1908 (2017), <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304042>.

¹⁴ 38 C.F.R. § 17.38(c).

¹⁵ CTR. FOR REPROD. RIGHTS, WHAT IF ROE FELL? (2019), <https://reproductiverights.org/what-if-roe-fell>.

¹⁶ Elizabeth Chuck, *Missouri Begins Hearing Over Planned Parenthood Clinic, State's Lone Abortion Clinic*, NBC NEWS (Oct. 28, 2019, 2:02 PM), <https://www.nbcnews.com/news/us-news/missouri-begins-hearing-over-planned-parenthood-clinic-state-s-lone-n1072736>.

¹⁷ NAT'L P'SHIP FOR WOMEN & FAMILIES, BAD MEDICINE: HOW A POLITICAL AGENDA IS UNDERMINING ABORTION CARE AND ACCESS 13 (3d ed. 2018), <http://www.nationalpartnership.org/our-work/resources/repro/bad-medicine-third-edition.pdf>.

unnecessary provider visits or unnecessary medical services. These barriers both delay care and prolong the time a patient must take to receive care.¹⁸ On average, a patient must wait at least a week between when they attempt to make an appointment and when they receive an abortion.¹⁹ All of these barriers and costs are exacerbated if a patient first seeks and is denied care by a VHA facility.

Delays have the effect of increasing the cost of abortion care. Abortion in the first trimester is substantially less expensive than in the second trimester.²⁰ The rising cost of abortion as gestational age increases poses a profound challenge to the affordability of the procedure for lower-income women. And because fewer clinics offer second-trimester abortions, a patient who has been delayed into the second trimester will typically be required to travel farther to obtain an abortion, thereby incurring additional travel and related costs, including costs for child care, transportation, or hotel stays.²¹ As a result, denials of care that result in delays can significantly drive up the cost for a patient seeking abortion care, which can push care out of reach—particularly for low-income veterans and those residing in states with few abortion providers.

It is unconscionable that the VA health care system imposes these burdens on veterans in need of essential health care. The Department of Veterans Affairs must urgently rescind the regulations prohibiting abortion at VHA, and ensure its medical benefits package includes abortion and abortion counseling just as it does all other pregnancy-related care.

III. Veterans must have full, equitable access to infertility care as part of their medical benefits package

In the U.S., millions of people are impacted by infertility. Approximately 12% of women ages 15-44²² struggle with infertility and almost 9% of men ages 25-44 report that they or their partner saw a doctor for an infertility issue.²³ While research on infertility incidence and access to infertility care use in the United States is limited, there is even less data available for the military community. However, a recent study by the Service Women’s Action Network (SWAN), which surveyed 799 female servicemembers and veterans, revealed that 37% of respondents struggled with infertility—over three times higher than the national average.²⁴ While this is not a nationally representative survey, it nevertheless indicates that infertility is of increasing concern among veterans, particularly as the number of female veterans continues to grow.

¹⁸ See *id.* at 21-22; see also VIRGINIA DEP’T OF HEALTH, REGULATIONS FOR LICENSURE OF ABORTION FACILITIES, PROPOSED REGULATION AGENCY BACKGROUND DOCUMENT 10 (2013), http://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\58\3563\6315\AgencyStatement_VDH_6315_v2.pdf.

¹⁹ See Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 CONTRACEPTION 334, 338-43 (2006) (Nothing that the median is seven days, while the average is 10 days. Moreover, poorer women wait two to three days longer than the typical woman).

²⁰ Rachel K. Jones et al., *Differences in Abortion Service Delivery in Hostile, Middle-Ground, and Supportive States in 2014*, 28 WOMEN’S HEALTH ISSUES 212, 215-16 (2018), [http://www.whijournal.com/article/S1049-3867\(17\)30536-4/abstract](http://www.whijournal.com/article/S1049-3867(17)30536-4/abstract).

²¹ Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008?*, 22 J. WOMEN’S HEALTH 706 (2013).

²² CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), *2017 Assisted Reproductive Technology Fertility Clinic Success Rates Report* (Oct. 2019), available at <https://www.cdc.gov/art/reports/2017/fertility-clinic.html>.

²³ CDC, *Infertility FAQs – Is Infertility Just a Woman’s Problem?*, <https://www.cdc.gov/reproductivehealth/infertility/index.htm> (last accessed March 15, 2020).

²⁴ SERVICE WOMEN’S ACTION NETWORK, *ACCESS TO REPRODUCTIVE HEALTH CARE: THE EXPERIENCES OF MILITARY WOMEN* (2018), https://www.servicewomen.org/wp-content/uploads/2018/12/2018ReproReport_SWAN-2.pdf.

In the course of their service, many veterans have been exposed to job-related risk factors that can cause infertility or are linked to a greater risk of infertility. For example, soldiers deployed in combat areas may experience service-related injuries that render them infertile. Combat-related injuries that adversely impact fertility include spine/spinal cord and head injuries, which particularly affect male fertility, and genital/pelvic trauma, which may affect fertility in both men and women.²⁵ Women who are deployed in combat zones often are also exposed to an additional risk factor most men are not: combat gear that is not designed for use by women. Ill-fitting combat gear can cause injuries, including injuries that could directly or indirectly affect fertility.²⁶ In addition, some military occupations may hold their own, unique risks. Exposure to toxic chemicals can harm the reproductive system and potentially cause infertility.²⁷ As a result, veterans who were exposed to harmful chemicals as an essential function of their jobs may be at substantially higher risk of infertility than other veterans or the civilian population at large. These include engineers handling solvents to clean or strip plane parts, servicemembers who specialize in hazardous waste cleanup, or those who are exposed to contaminated water and burn pits during deployment. While more research is needed to obtain reliable data, it is likely that exposure to these risk factors results in higher infertility rates among servicemembers and veterans.

When veterans struggle to conceive and seek out care, they are subject to discriminatory restrictions on insurance coverage, the high costs of in vitro fertilization (IVF) services, and logistical and systemic barriers to care. The Veterans Health Administration's medical benefits package specifically excludes coverage for IVF.²⁸ However, pursuant to a provision first attached to the annual appropriations bill in 2016 and included every year since then, VHA currently funds IVF for a narrow subset of veterans. Because the current provision is tied to the annual appropriations bill, the funding for even this narrow population of veterans is not permanent.

Under the provision, only veterans who are diagnosed with a service-related condition that led to their inability to procreate with their different-sex spouse using their own gametes are eligible for IVF.²⁹ It is often difficult to prove that a service-connected illness or injury caused clinical infertility, unless it manifests as physical trauma to the reproductive organs.³⁰ VHA's eligibility requirements are designed to mirror those provided by the Department of Defense under TRICARE,³¹ which effectively exclude single and unmarried veterans, those in same-sex

²⁵ Ginny L. Ryan, *Investigator-Initiated Research 13-294 — Human Services Research & Development Study: Impact of Sexual Assault and Combat-Related Trauma on Fertility in Veterans*, U.S. DEP'T OF VETERANS AFFAIRS (last visited June 14, 2019), https://www.hsr.d.research.va.gov/research/abstracts.cfm?Project_ID=2141704065.

²⁶ See, e.g. Karen Jowers, *Do Military Women Have Higher Rates of Infertility Than Civilians?*, MILITARY TIMES (Dec. 14, 2018), <https://www.militarytimes.com/pay-benefits/2018/12/14/do-military-women-have-higher-rates-of-infertility-than-civilians/>; *Infertility?*, CTR. FOR REPROD. MED. & ADVANCED REPROD. TECH., <https://ivfminnesota.com/military-women/> (last visited June 28, 2020).

²⁷ Joseph Pizzorno, *Environmental Toxins and Infertility*, 17 INTEGRATIVE MED. 8, 8-10 (2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6396757/>.

²⁸ 38 CFR § 17.38(c)(2).

²⁹ Continuing Appropriations and Military Construction, Veterans Affairs and Related Agencies Appropriations Act, 2017, and Zika Response and Preparedness Act, Pub. L. No. 114-223, § 260, <https://www.congress.gov/bill/114th-congress/house-bill/5325>; Fertility Counseling and Treatment for Certain Veterans and Spouses, 38 C.F.R. § 1762 (2019), <https://www.federalregister.gov/documents/2019/03/07/2019-04096/fertility-counseling-and-treatment-for-certain-veterans-and-spouses>.

³⁰ Lori Gawron et al., *Impact of Deployment on Reproductive Health in U.S. Active-Duty Servicewomen and Veterans*, 36 SEMINARS IN REPROD. MED. 361 (2018), doi:10.1055/s-0039-1678749.

³¹ The Department of Veterans Affairs notes: "For the purposes of this section, 'a service-connected disability that results in the inability of the veteran to procreate without the use of fertility treatment' means, for a male veteran, a service-connected injury or illness that prevents the successful delivery of sperm to an egg; and, for a female veteran with ovarian function and a patent uterine cavity, a service-connected injury or illness that prevents the egg from being successfully fertilized by a sperm. This definition parallels requirements in DoD policy guidance for an

marriages, those who cannot use their own gametes and reproductive organs, and those who cannot prove a service-connected illness or injury as ineligible. As a result, non-eligible individuals from these groups must seek care from non-VA providers, where they face substantially higher out-of-pocket costs that are prohibitive to many.

The out-of-pocket cost of IVF is substantial. The average cost of a single IVF cycle in the United States is over \$20,000 when including necessary medications and tests.³² Although success rates vary, the rate of live births following first-use IVF for women under the age of 35 using their own oocytes in 2018 was only 30%.³³ The chances of live birth increase with each cumulative IVF cycle,³⁴ but multiple cycles result in increased costs. This forces some people to consider taking out loans, turning to crowdfunding platforms, getting treatments in other countries with lower costs, or moving to states where IVF insurance coverage is mandated.³⁵

Women who have insurance coverage for IVF are more likely to have a successful live birth because they continue to access care over multiple cycles, versus women who pay out of pocket and can only afford a single cycle.³⁶ High out-of-pocket costs can lead women to discontinue IVF care after one unsuccessful IVF cycle.³⁷ Women without insurance coverage, in particular, are three times more likely than women *with* insurance coverage to discontinue infertility services after one round.³⁸

Congress and the Administration should take immediate steps to eliminate the discriminatory policies that restrict access to this essential care. We recommend the implementation of policies to ensure that all servicemembers and veterans receive insurance coverage for “non-coital” reproductive services such as intrauterine insemination (IUI) and IVF, without limitations with regard to whether their infertility is service-connected, whether they are impacted by clinical or social infertility (e.g., they are single or in same-sex partnerships), their marital status, or their sexual orientation. Such insurance coverage should include at least three cycles of IVF. An effective means of achieving this is to decouple the VA’s policy for providing infertility care from the Department of Defense’s policy on the same. Doing so would allow the VA to better meet the unique needs of the population they serve, as well as incorporate new infertility services as medical treatment continues to evolve and improve. Uncoupling the policy from DOD’s healthcare policy will thus provide VA an opportunity to provide veterans with more equitable access to the infertility care they need to build their desired families.

active duty service member who is seriously or severely ill/injured (Category II or III) to receive fertility counseling and treatment using ART.” 82 Fed. Reg. 6273 (January 19, 2017).

³² *Cost of IVF: Cost Components*, FERTILITYIQ (last accessed May 14, 2020), <https://www.fertilityiq.com/ivf-in-vitro-fertilization/costs-of-ivf#cost-components>;

³³ Society for Assisted Reproductive Technology (SART), Preliminary National Summary Report for 2018, Patient’s Own Eggs, Live Births per Intended Egg Retrieval (First Embryo Transfer), (First Embryo Transfer) [filtered for first IVF], https://www.sartcorsonline.com/rptCSR_PublicMultYear.aspx#patient-cumulative.

³⁴ Louise Stewart, *How Effective Is In Vitro Fertilization, and How Can It Be Improved?*, 95 FERTILITY & STERILITY 1677 (2011), <https://doi.org/10.1016/j.fertnstert.2011.01.130>.

³⁵ Amy Klein, *I.V.F. is Expensive. Here’s How to Bring Down the Cost*, N.Y. TIMES (Apr. 18, 2020), <https://www.nytimes.com/article/ivf-treatment-costs-guide.html>; see also Megan Leonhardt, *Women are Traveling Far and Wide for Affordable IVF – Here’s Why It’s So Expensive*, CNBC (Aug. 13, 2019), <https://www.cnbc.com/2019/08/13/women-are-traveling-far-and-wide-for-affordable-ivf.html>.

³⁶ Emily S. Jungheim, *In Vitro Fertilization Insurance Coverage and Chances of a Live Birth*, 317 J. AM. MED. ASS’N 1273 (Mar. 2017), doi:10.1001/jama.2017.0727.

³⁷ Prosper Marketplace, *Fertility Treatments in the United States: Sentiment, Costs, and Financial Impact*, PROSPER: PROSPER BLOG (May 20, 2019), <https://blog.prosper.com/2015/05/20/fertility-treatments-in-the-united-states-sentiment-costs-and-financial-impact/>.

³⁸ Bronwyn Bedrick et al., *Factors Associated with Early In Vitro Fertilization Treatment Discontinuation*, 112 FERTILITY & STERILITY 105, 105-111 (2019), [https://www.fertstert.org/article/S0015-0282\(19\)30250-X/fulltext](https://www.fertstert.org/article/S0015-0282(19)30250-X/fulltext).

Additionally, more research is needed to assess the scope and cause of infertility among veterans and disparities in access to care. Congress and the administration should take immediate steps to collect and make publicly available, on a regular basis, data on infertility among veterans, including: the number of self-reported cases of infertility, either clinical or social; the number of diagnosed clinical infertility cases; the number of clinical infertility diagnoses that are “unexplained”; the number of people diagnosed with clinical infertility and also known to be exposed to service-related toxic chemicals in the course of their military service; the number of patients who would be eligible for infertility services but for their marital status; the extent to which there are data gaps in infertility incidence and access to care for veterans of color; and whether there is a discrepancy between self-reported incidence of infertility and rates assessed by diagnostic codes within the VHA system.

IV. Congress must improve data collection to better understand the scope and impact of the maternal health crisis on veterans and VHA must take subsequent steps to reduce adverse maternal health outcomes among veterans if they exist.

The United States is experiencing a maternal health crisis which disproportionately impacts Black and Indigenous birthing people. With the highest maternal mortality ratio in the developed world, the U.S. is one of only thirteen countries where maternal mortality is on the rise.³⁹ Black women are nearly four times more likely than white mothers to suffer a maternal death,⁴⁰ and twice as likely to suffer maternal morbidity.⁴¹ Indigenous women are two and a half times more likely than white women to die from a maternal death.⁴² The majority of U.S. maternal deaths are preventable.⁴³ In the U.S., racial and ethnic disparities in health are closely linked to social and economic inequalities, reflecting systemic obstacles to health that harm women of color especially. Factors such as poverty, lack of access to health care, and exposure to racism all undermine health and contribute to the disproportionately high number of maternal deaths among Black and Indigenous women.⁴⁴ Further, reports are already indicating that the COVID-19 pandemic is putting an additional strain on the health care system and exacerbating the underlying maternal health crisis facing Black and Indigenous birthing people.⁴⁵

³⁹ The United States has a maternal mortality ratio (MMR) of 14, placing the U.S. behind 45 other countries. WORLD HEALTH ORGANIZATION (WHO) ET AL., ESTIMATES BY WHO, UNICEF, UNFPA, WORLD BANK GROUP AND THE UNITED NATIONS POPULATION DIVISION 99-104 (2019), <https://www.unfpa.org/featured-publication/trends-maternal-mortality-2000-2017>.

⁴⁰ Reproductive Health: Pregnancy Mortality Surveillance System, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html> (last reviewed June 4, 2019); Andrea A. Creanga et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008-2010*, 210 AM. J. OBSTET. GYNECOL. 435, 437 (2014).

⁴¹ *Id.*

⁴² Emily E. Petersen et al., *Morbidity and Mortality Weekly Report, Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017*, CTRS. FOR DISEASE CONTROL AND PREVENTION (May 10, 2019), <https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm>.

⁴³ *Morbidity & Mortality Wkly Rep.: Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017*, CTRS. FOR DISEASE CONTROL AND PREVENTION (May 2019), https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w.

⁴⁴ See Francine Coeytaux et al., *Maternal Mortality in the United States: A Human Rights Failure*, 83 CONTRACEPTION 189-93 (2011); Arline T. Geronimus, *The weathering hypothesis and the health of African-American women and infants: evidence and speculations*, 2 ETHNICITY & DISEASE 207-221 (1992), <https://www.ncbi.nlm.nih.gov/pubmed/1467758> (finding a kind of toxic stress triggers the premature deterioration of the bodies of Black women as a consequence of repeated exposure racial discrimination and that this effect could lead to poor pregnancy outcomes).

⁴⁵ See, e.g., Sandhya Raman, *COVID-19 amplifies racial disparities in maternal health*, ROLL CALL, May 14, 2020 available at <https://www.rollcall.com/2020/05/14/covid-19-amplifies-racial-disparities-in-maternal-health/>; Joia Crear-Perry, *Black Mamas Can Thrive*

Despite these troubling maternal health outcomes, the United States does not adequately prioritize or monitor maternal deaths. The lack of systematically collected maternal mortality and morbidity data precludes comparisons across states and regions and undermines accountability for preventable maternal deaths and injuries.⁴⁶ Even less is known about the maternal mortality and morbidity rates among the United States' nearly two million women veterans.⁴⁷ The VA does not operate a Maternal Mortality Review Committee and as such there is a critical lack of data on the maternal health outcomes of veterans, particularly veterans of color, and the scope and impact of the maternal mortality crisis on this population.

Regarding the need for more data, the Protecting Moms Who Served Act (H.R. 958), reintroduced in the House of Representatives in February of this year, aims to create a comprehensive report of maternal health outcomes among veterans, with a particular focus on racial and ethnic disparities. Congress must pass this Act as an important first step to gather the data necessary to better serve veterans and their maternal health care needs during the existing maternal mortality crisis. If the data shows that the maternal mortality crisis exists among the nation's veterans, Congress must act to guarantee that those who serve our country are supported throughout the entirety of their reproductive lives and guaranteed high quality, respectful maternal health care.

V. Conclusion

The Center for Reproductive Rights deeply appreciates the opportunity to submit its testimony to the Committee and commends the Committee for addressing this critical issue. As the Committee examines access to reproductive health care at the VA, we urge it to take the appropriate actions to ensure that our veterans receive the highest standard of reproductive health care.

During Childbirth, COVID-19 Or Not, ESSENCE, March 19, 2020 available at <https://www.essence.com/feature/black-mamas-childbirth-covid-19-coronavirus/>; Claire Cleveland, *Coronavirus Is Stressing Pregnant Women And New Mothers Out. These Researchers Are Trying to Understand How to Help*, CPR NEWS, May 23, 2020 available at <https://www.cpr.org/2020/05/23/coronavirus-is-stressing-pregnant-women-and-new-mothers-out-these-researchers-are-trying-to-understand-how-to-help/>; Nina Martin, *What Coronavirus Means for Pregnancy, and Other Things New and Expecting Mothers Should Know*, PROPUBLICA, Mar. 19, 2020 available at <https://www.propublica.org/article/coronavirus-and-pregnancy-expecting-mothers-q-and-a>.

⁴⁶ *MMR Map*, REVIEW TO ACTION <http://www.reviewtoaction.org/content/mmr-map> (last visited Sept. 25, 2019).

⁴⁷ *Veteran Population*, U.S. DEPT OF VETERANS AFFAIRS (last updated May 21, 2020), https://www.va.gov/vetdata/veteran_population.asp.