October 11, 2022

Attn: Dr. Shereef Elnahal, Undersecretary for Health

Department of Veterans Affairs
810 Vermont Ave. NW
Washington, DC 20420

Re: RIN 2900-AR57, Reproductive Health Services

The Center for Reproductive Rights respectfully submits the following comments in support of the interim final rule ("IFR" or "the rule") of the Department of Veterans Affairs ("VA" or "the Department") to amend its medical benefits to remove the exclusion on abortion counseling and permit abortions in case of rape, incest, and to save the life and health of the pregnant person (RIN 2900-AR57).

Since 1992, the Center for Reproductive Rights has used the power of law to advance reproductive rights as fundamental human rights worldwide. Our litigation and advocacy over the past 30 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 obstetric 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 individuals are 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 write in strong support of this rule, which will expand access to comprehensive reproductive health care for many veterans and beneficiaries of the Civilian Health and Medical Program of the Department of Veteran's Affairs ("CHAMPVA"). As a procedural matter, VA was correct to issue this rule as an IFR, because the ongoing public health crisis surrounding abortion justifies an IFR under the Administrative Procedure Act's good cause exception. Further, VA can promulgate this rule under the broad authority granted it by the Veterans' Health Care Eligibility Reform Act of 1996. The new rule is a dramatic improvement over the earlier medical benefits package, which deprived veterans and CHAMPVA beneficiaries of essential health care and caused serious consequences for veterans in need of care. Finally, the rule takes important steps to advance access to abortion care, including by lifting the ban on abortion counseling entirely and permitting abortion in certain circumstances, but we urge the Department to lift the ban on abortion entirely.

I. VA was justified to issue the rule as an interim final rule because it falls within the Administrative Procedure Act's good cause exception.

The Administrative Procedure Act confers authority to Secretaries to promulgate interim final rules as necessary or appropriate and provides an exception to the standard notice and comment

requirement and 30-day requirement when there is a showing of a good cause.[1] The good cause exception applies where there is "a true and supported finding or supportable finding of necessity or emergency" that is made and published.[2] Importantly, circumstances outside agency control may require a rapid resolution in the public interest, justifying an IFR.

Such an emergency presents itself here, where the aftermath of the Supreme Court decision overturning *Roe v. Wade* in *Dobbs v. Jackson Women's Health Organization* has created a staggering public health crisis. Going through notice and comment would be "contrary to the public interest" because the rule is urgently needed to mitigate the effects of the ongoing public health crisis for pregnant veterans and CHAMPVA beneficiaries. Lack of adequate reproductive health services can have profound impacts, including financial insecurity, increased risk of intimate partner violence, and maternal and neonatal deaths.[3]

The Supreme Court decision overturning *Roe* has unleashed chaos in our medical system as state after state has banned abortion in quick succession and large swaths of the country no longer have access to abortion care.[4] According to the National Partnership for Women & Families, it is estimated that up to 53 percent of veterans of reproductive age may be living in states that have already banned or are likely to soon ban abortion following the *Dobbs* decision.[5] Patients who live in a state that prohibits abortion or who are denied abortion care may find it difficult or even impossible to find a willing and available provider in a reasonable timeframe. Even prior to the Supreme Court's decision to overturn the constitutional right to abortion in *Dobbs*, 89 percent of counties in the United States did not have a single abortion clinic, and some counties that had a clinic only provided abortion services on certain days.[6] Since then, many more clinics have shuttered.[7]As of October 11, 2022, abortion bans in the U.S. have left over 70 million people across 12 states without access to abortion.[8] Twelve states are enforcing total bans, one state is

[1] The good cause exception applies where rulemaking is "impracticable, unnecessary, or contrary to the public interest. 5 U.S.C. § 553(b).

[2] *See, e.g.*, S. REP., No. 752, at 200 (1945) ("A true and supported or supportable finding of necessity or emergency must be made and published").

[3] 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/wp-content/uploads/2020/12/USP-COVID-FS-Interactive-Update.pdf

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

[5] NAT'L P'SHIP FOR WOMEN & FAMS, ISSUE BRIEF: STATE ABORTION BANS COULD HARM NEARLY 15 MILLION WOMEN OF COLOR (2022), http://www.nationalpartnership.org/ our-work/ economic-justice/ reports/ state-abortion-bans-harm-woc.html.

[6] NAT'L P'SHIP FOR WOMEN & FAMS., BAD MEDICINE: HOW POLITICAL AGENDA IS UNDERMINING ABORTION CARE AND ACCESS IN OKLAHOMA (2019), https://www.nationalpartnership.org/our-work/repro/reports/bad-medicine-oklahoma.html.

[7] Marielle Kirstein,et al., *100 Days Post-Roe: At Least 66 Clinics Across 15 US States Have Stopped Offering Abortion Care*, GUTTMACHER INSTITUTE (Oct. 6, 2022), https://www.guttmacher.org/2022/10/100-days-post-roe-least-66-clinics-across-15-us-states-have-stopped-offering-abortion-care.

[8] Calculated using the 2020 U.S. Census Apportionment Population numbers.

enforcing a six-week ban, and seven other states have tried to prohibit abortion, but are blocked by court orders as of this writing.[9] As a result, many veterans must travel long distances at great expense to access care, if they are able to access care at all.[10] In addition, in certain areas, the increased demand resulting from patients traveling from states that prohibit abortion results in significantly increased wait times[11] and, in some cases, patients may be turned away altogether.[12]

Since the overturn of *Roe*, there has been a stark increase in hospitals and providers turning away pregnant patients in need of abortion care or miscarriage management even in emergency situations.[13] Although additional guidance provided by the Department of Health and Human Services in July makes clear that the Emergency Medical Treatment & Labor Act ("EMTALA") (which protects the care a person needs when presenting with an "emergency medical condition"[14]) preempts any state laws or mandates that employ a more restrictive definition of an emergency medical condition,[15] health care providers in states that ban abortion still fear legal consequences or may be restricted by hospital policy as to when they may treat patients.[16] They have been placed in an impossible situation, where providing the health care their patients need –

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[9] CTR. FOR REPROD. RIGHTS, AFTER ROE FELL: ABORTION LAWS BY STATE, https://reproductiverights.org/after-roe-fell-abortion-laws-by-state/ (last visited Sept. 30, 2022).

[10] NAT'L P'SHIP FOR WOMEN & FAMS., BAD MEDICINE: HOW POLITICAL AGENDA IS UNDERMINING ABORTION CARE AND ACCESS IN OKLAHOMA (2019), https://www.nationalpartnership.org/our-work/repro/reports/bad-medicine-oklahoma.html.

[11] Margot Sanger-Katz, Claire Cain Miller & Josh Katz, *Interstate Abortion Travel Is Already Straining Parts of the System,* N.Y. TIMES, (Sept. 19, 2022), https://www.nytimes.com/2022/07/23/upshot/abortion-interstate-travel-appointments.html.

[12] Marty Schladen, *Affidavits: More Pregnant Minors Who Were Raped Denied Ohio Abortions,* OHIO CAPITAL JOURNAL, (Sept. 22, 2022), https://ohiocapitaljournal.com/2022/09/22/affidavits-more-pregnant-minors-who-were-raped-denied-ohio-abortions/ (quoting Allegra Pierce, a medical assistant at Preterm-Cleveland, saying that "[e]ven those patients who are able to travel out of state often have a hard time getting an appointment due to increasingly long wait times at clinics in states where abortion is still legal."); Laura Hancock, *Hamilton County Judge Immediately Halts Enforcement of Ohio's Fetal 'Heartbeat' Abortion Law for 14 Days; Abortion Now Legal Until 22 Weeks,* CLEVELAND.COM (Sept. 14, 2022), https://www.cleveland.com/news/2022/09/ohio-judge-halts-enforcement-of-fetal-heartbeat-abortion-law-for-14-days.html.

[13] *See, e.g.,* Kate Zernike, *Medical Impact of Roe Reversal Goes Well Beyond Abortion Clinics, Doctors Say*, NEW YORK TIMES, (Sept. 10, 2022), https://www.nytimes.com/2022/09/10/us/abortion-bans-medical-care-women.html; Christine Vestal, *Some Abortion Bans Put Patients, Doctors at Risk in Emergencies*, STATELINE, AN INITIATIVE OF THE PEW CHARITABLE TRUSTS (Sept. 7, 2022), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/09/01/some-abortion-bans-put-patients-doctors-at-risk-in-emergencies.

[14] 42 U.S.C. §1395dd(b)(1).

[15] U.S. DEPT. OF HEALTH & HUM. SERVS., HHS SECRETARY LETTER TO HEALTH CARE PROVIDERS ABOUT EMERGENCY MEDICAL CARE (Jul. 11, 2022), https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-care-providers.pdf.

[16] A Post Roe America: The Legal Consequences of the Dobbs Decision Before the Sen. Comm. on the Judiciary, 117th Cong. (2022) (oral testimony of Colleen P. McNicholas, Chief Medical Officer, Planned Parenthood of the St. Louis Region and Southwest Missouri) https://www.judiciary.senate.gov/meetings/a-post-roe-america-the-legal-consequences-of-the-dobbs-decision (sharing her experience as a leader in the American College of Obstetricians and Gynecologists).

even emergency care – could potentially expose them to prosecution and civil suit in states that ban abortion.[17] These circumstances put the lives and health of pregnant patients, including veterans, at risk, requiring urgent action from VA to protect the health and lives of veterans and CHAMPVA-beneficiaries. Moreover, while EMTALA is an important tool to protect the lives of patients, it merely requires stabilizing patients who are facing an immediate life-threatening emergency. EMTALA does nothing to ensure access to the range of abortion care that is affected by this abortion access crisis, and that the IFR takes steps to address.

These circumstances support the Department's finding that "leaving veterans and CHAMPVA beneficiaries without access to abortions and abortion counseling puts their health and lives at risk,"[18] necessitating the issuance of this interim final rule. VA has acted within its authority to issue this rule as an interim final rule with immediate effect.

II. VA has the authority to promulgate this rule under the Veterans' Health Care Eligibility Reform Act of 1996.

With the Veterans' Health Care Eligibility Reform Act of 1996, Congress granted VA broad rulemaking authority to "furnish hospital care and medical services . . . which the Secretary determines to be needed."[19] This authority is not restricted by the Veterans Health Care Act of 1992, but rather supersedes it. In doing so, the law grants VA the authority to provide any reproductive health care it finds necessary to deems "needed" for veterans, including abortion care.

Legislative history demonstrates that the goal of the Veterans' Health Care Eligibility Reform Act of 1996 was to "substitute a single uniform eligibility standard for the complex array of standards governing access to VA hospital and outpatient care" and ensure that "medical judgment rather than legal criteria will determine when care will be provided and the level at which that care will be furnished."[20] Accordingly, in 1999, VA promulgated a medical benefits package for veterans to include care that would "promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice."[21]

This medical benefits package included both infertility care and general pregnancy and delivery services in the medical benefits package when it was promulgated in 1999, relying on VA's

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[17] Reese Oxner & María Méndez, *Texas Hospitals are Putting Pregnant Patients at Risk by Denying Care Out of Fear of Abortion Laws, Medical Gro Says*, TEXAS TRIBUNE (Jul. 15, 2022), https://www.texastribune.org/2022/07/15/texas-hospitals-abortion-laws/; AP, *Letter Says Texas Hospitals Reportedly Refusing Abortion Care*, NBC DFW (Jul. 15, 2022), https://www.nbcdfw.com/news/local/texas-news/letter-says-texas-hospitals-reportedly-refusing-abortion-care/3015545/.

[18] 87 Fed. Reg. 55287 (Sept. 9, 2022).

[19] 38 U.S.C. § 1710(a)(1).

[20] H.R. REP. NO. 104-690, at 4 (1996).

[21] 38 CFR § 17.38(b).

authority granted by the Veterans' Health Care Eligibility Reform Act to provide this care. Covered pregnancy care now included "prenatal, intra-partum, and post-partum care of the mother."[22] Under the 1992 law, VA would have been prohibited from providing any infertility care and could only provide pregnancy and delivery care under section 106 if the pregnancy was complicated or a service-related condition increased the risks of pregnancy complications. Accordingly, the VA has long understood the Veterans' Health Care Eligibility Reform Act of 1996 to supersede the restrictions on reproductive health care enumerated in Section 106 of the 1992 Veterans Health Care Act. As the IFR notes, "VA no longer relies on Section 106 of the VHCA to provide such services or any other services."[23]

In promulgating this rule, the VA relies on the same authority granted by the Veterans' Health Care Eligibility Reform Act to determine that abortion access in cases of rape, incest, and to preserve the health and life of the pregnant person is "needed." This determination is a long-overdue recognition of the health benefits of abortion care as an essential service for veterans who can become pregnant, and an acknowledgment that in the current political environment, veterans who are unable to access medically indicated abortion services at VA may not be able to obtain that care at all, to the detriment of their health and lives. Because Congress granted VA the authority to make the determination of what care is "needed" for the health of veterans, VA clearly acted within its authority to authorize exceptions for abortion care in cases of rape, incest and life and health of the pregnant veteran.

III. The IFR is a vital step towards ensuring access to abortion care and counseling for all veterans and CHAMPVA beneficiaries.

Abortion is a human right, and a normal and common part of health care.[24] Everybody deserves to have access to abortion, regardless of where they live and how they receive their care, and every person has the right to decide if, when, and how to have a family.

Further, access to comprehensive sexual and reproductive health services, including access to abortion care, is essential to gender equity and equality. Abortion restrictions rely on and reinforce harmful stereotypes about gender roles and pregnant people's decision-making instead of offering support, undermining their ability to control their own lives and well-being. When someone makes the decision to have an abortion, they should be able to access the care they need with respect and dignity, free from burdens, barriers, and stigma.

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[22] U.S. DEPT. OF VETERANS AFFS., VHA HANDBOOK 1330.03 §§ 2.a, 3.b (Oct. 5, 2012).

[23] 87 Fed. Reg.55289 (Sept. 9, 2022).

[24] *See, e.g.*, U.N. Human Rights Committee ("HRC"), General Comment No. 36: Article 6 of the ICCPR, on the right to life, ¶ 8, U.N. Doc. CCPR/C/GC/36 (Sept. 3, 2019) [hereinafter HRC General Comment No. 36]; Committee on Economic, Social and Cultural Rights ("CESCR Committee"), General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), ¶¶ 5, 10, 13, 45, U.N. Doc. E/C.12/GC/22 (May 2, 2016) [hereinafter CESCR Committee General Comment No. 22]; Committee on the Elimination of Discrimination against Women ("CEDAW Committee"), General Recommendation No. 24: Article 12 of the Convention (Women and Health), ¶¶ 11, 14, U.N. Doc. A/54/38/Rev.1, Chap. I (1999) [hereinafter CEDAW Committee General Recommendation No. 24].

The new rule makes great progress towards that goal for the growing population of veterans who may need abortion care by lifting the ban on abortion counseling and, for the first time, permitting abortion access in cases of rape, incest, and to protect the life and health of the pregnant person. According to VA, over 155,000 veterans who may need abortion care and rely on VA for health care live in states with abortion bans and restrictions.[25] Women are the fastest growing cohort within the veteran community, and the percentage of women veterans is expected to grow by more than half in the next twenty years.[26] Within that group, women of reproductive age between ages 18-44 are the fastest growing subset of new VA users.[27] Further, research estimates that the veteran community includes more than 11,000 transgender men, in addition to non-binary veterans and veterans who identify with a different gender, many of whom need abortion care.[28] Moreover, female veterans are more likely to live in poverty than male veterans, and, similarly, transgender veterans are more likely to live in poverty than their cisgender peers.[29] For pregnant veterans who may need an abortion due to rape, incest, or to preserve their health or life, this rule represents a big step towards the comprehensive, coordinated reproductive health care they need and deserve.

Importantly, the IFR also extends access to this care to CHAMPVA beneficiaries, expanding abortion access and counseling for many veterans' loved ones and caregivers. This will benefit the nearly 50,000 CHAMPVA beneficiaries who may need abortion care and live in states with abortion bans and restrictions. [30]

a. The interim final rule makes great advances for veterans' reproductive health, but more remains to be done.

We strongly agree with VA's determination that access to abortion and abortion counseling services is necessary to promote, preserve, and restore the health of veterans.

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[25] 87 Fed. Reg. 55295 (Sept. 9, 2022).

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

[27] Sarah A. Friedman et al., *New Women Veterans in the VHA: A Longitudinal Profile*, 21 Women's Health Issues 103, 103-11 (2011), https://www.whijournal.com/article/S1049-3867(11)00110-1/fulltext/.

[28] GARY J. GATES & JODY L. HERMAN, THE WILLIAMS INSTITUTE, TRANSGENDER MILITARY SERVICE IN THE UNITED STATES3-4 (2014), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Military-Service-US-May-2014.pdf.

[29] DISABLED AMERICAN VETERANS, WOMEN VETERANS: THE JOURNEY AHEAD 9 (2018), https://www.dav.org/wp-content/uploads/2018_Women-Veterans-Report-Sequel.pdf; *See also* Janelle Downing et al., *Transgender and Cisgender Veterans Have Few Health Differences*, 37:7 Health Affairs 1160-68 (2018), https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2018.0027.

[30] 87 Fed. Reg. 55295 (Sept. 9, 2022).

1. *We strongly support the rule's elimination of the ban on abortion counseling for veterans and CHAMPVA beneficiaries.*

Pregnancy options counseling is an important service for many people when they first discover their pregnancy, and we support the rule's elimination of the ban on abortion counseling for veterans and CHAMPVA beneficiaries. As VA notes in the preamble to the rule, abortion counseling is "a part of pregnancy options counseling and is a component of comprehensive, patient-centered, high quality reproductive health care both as a responsibility of the provider and a right of the pregnant veteran."[31] This is consistent with medical standards put forth by leading medical associations such as the American College of Obstetricians and Gynecologists and the American Medical Association. Medical ethics require health care providers to ensure there is informed consent, including by informing patients of all of their pregnancy options.[32]

Informed consent is a necessary principle of patient-centered decision-making intended to help balance the power dynamics between health care providers and patients. It also ensures patients have full autonomy over what will happen to their bodies. Informed consent requires providers to disclose relevant and medically accurate information about treatment choices and alternatives so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether.[33] Accordingly, the VA's decision to lift the ban on abortion counseling is a critical and necessary change. We firmly support VA's decision to ensure that veterans have the opportunity to be counseled on all of their health care options so they can freely decide on the course of treatment that is best for their health and lives. Moreover, this change will reduce barriers to care by allowing VA to give referrals for care that cannot be provided by VA.

2. *The rule takes important steps to advance abortion access for veterans and CHAMPVA beneficiaries, but the final rule should lift the ban entirely.*

We also strongly support the steps the rule has taken to advance access to abortion care for veterans by allowing VA to provide abortion care. As described in detail above, the United

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[31] 87 Fed. Reg. 55292 (Sept. 9, 2022).

[32] *See e.g.,* AMERICAN COLLEGE OF PHYSICIANS, *ETHICS MANUAL* (6th Ed. 2012), https://www.acponline.org/clinical-information/ethics-and-professionalism/acp-ethics-manual-sixth-edition/acp-ethics-manual-sixth-edition#informed ("The ethical duty to disclose relevant information about human reproduction to the patient may conflict with the physician's personal moral standards on abortion, sterilization, contraception, or other reproductive services. A physician who objects to these services is not obligated to recommend, perform, or prescribe them. As in any other medical situation, however, the physician has a duty to inform the patient about care options and alternatives, or refer the patient for such information, so that the patient's rights are not constrained. Physicians unable to provide such information should transfer care as long as the health of the patient is not compromised."); AMERICAN NURSES ASSOCIATION, *CODE OF ETHICS FOR NURSES WITH INTERPRETIVE STATEMENTS, Sec. 1.4* (2015) ("Patients have the moral and legal right to determine what will be done with their own person; to be given accurate, complete and understandable information in a manner that facilitates an informed decision.").

[33] *See* AMERICAN MEDICAL ASSOCIATION, *CODE OF MEDICAL ETHICS OPINION 2.1.1: INFORMED CONSENT*, https://www.ama-assn.org/delivering-care/informed-consent ("Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care.").

States is facing an ongoing public health crisis on abortion access, which puts the life and health of veterans and CHAMPVA beneficiaries at risk due to the proliferation of state abortion bans and an abortion provider shortage that limits their access to care even in states where abortion is still legal. The rule takes critical steps to mitigate the impact of this crisis on pregnant veterans and CHAMPVA beneficiaries.

The final rule also appropriately acknowledges that abortion access is needed because pregnancy and childbirth in the United States "can result in physical harm and even death for certain pregnant individuals."[34] The maternal mortality risk for pregnant people in the United States is staggeringly high, especially for Black, Hispanic, and Indigenous birthing people who experience far higher rates of pregnancy-related death and complications than white birthing people.[35] As the Armed Forces and the veteran population continue to become more diverse,[36] the rule is an important step to reduce this risk among veterans by permitting access to abortion in cases of health and life endangerment.

Additionally, the VA serves a particularly vulnerable population that is at risk for adverse pregnancy outcomes.[37] As the rule notes, veterans "of reproductive age, in particular, have high rates of chronic medical and mental health conditions that may increase the risks associated with pregnancy." [38] In particular, posttraumatic stress disorder ("PTSD") affects about one in every

[34] 87 Fed. Reg. 55291 (Sept. 9, 2022).

[35] Maria E. Thoma & Eugene R. Declerq, *All-Cause Maternal Mortality in the US Before vs During the COVID-19 Pandemic*, 5 JAMA OPEN NETWORK 1, 1-4 (2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2793640; CTRS. FOR DISEASE CONTROL & PREVENTION, MATERNAL MORTALITY RATES IN THE UNITED STATES, 2020 (2022), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm ("In 2020, the maternal mortality rate for non-Hispanic Black women was 55.3 deaths per 100,000 live births, 2.9 times the rate for non-Hispanic White women (19.1) (Figure 1 and Table). Rates for non-Hispanic Black women were significantly higher than rates for non-Hispanic White and Hispanic women. The increases from 2019 to 2020 for non-Hispanic Black and Hispanic women were significant."); SUSANNA TROST ET AL., PREGNANCY-RELATED DEATHS: DATA FROM MATERNAL MORTALITY REVIEW COMMITTEES IN 36 US STATES, 2017–2019, CTRS. FOR DISEASE CONTROL & PREVENTION (2022), https://www.cdc.gov/reproductivehealth/maternal-mortality/docs/pdf/Pregnancy-Related-Deaths-Data-MMRCs-2017-2019-H.pdf; SUSANNA TROST ET AL., PREGNANCY-RELATED DEATHS AMONG AMERICAN INDIAN OR ALASKA NATIVE PERSONS: DATA FROM MATERNAL MORTALITY REVIEW COMMITTEES IN 36 US STATES, 2017–2019, CTRS. FOR DISEASE CONTROL & PREVENTION (2022), https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc-aian.html. *See also,* U.N. CERD, *International Convention on the Elimination of All Forms of Racial Discrimination*: *Concluding observations on the combined tenth to twelfth reports of the United States of America*, CERD/C/USA/CO/10-12, para 35 (Sept. 21, 2022) (noted that in the United States, "racial and ethnic minorities are disproportionally impacted by higher rates of maternal mortality and morbidity; higher risk of unwanted pregnancies and lack of means to overcome socioeconomic and other barriers to access safe abortion.").

[36] Amanda Barroso, *The Changing Profile of The U.S. Military: Smaller in Size, More Diverse, More Women in Leadership*, PEW RESEARCH CENTER, (Sept. 10, 2019), https://www.pewresearch.org/fact-tank/2019/09/10/the-changing-profile-of-the-u-s-military/.

[37] 87 FR 55287. (Sept. 9, 2022).

[38] *Id.*

twenty reproductive-aged individuals that are capable of pregnancy, [39] but this number is much higher for pregnant veterans, impacting 13 to 21 percent of pregnant veterans in the VA health care system .[40] In 2017, the VA's Office of Research and Development reported that PTSD may be a risk factor for both gestational diabetes and pre-eclampsia,[41] common pregnancy complications that can lead to serious health effects for both parent and child if left untreated. [42] Moreover, veterans who have experienced sexual trauma, which is reported by veterans at a higher rate than the general population, may experience serious traumatic stress with being forced to carry a pregnancy, in addition to compounding mental health conditions existing prior to pregnancy, like PTSD, when forced to continue an unwanted pregnancy.[43] The unique health care needs of this population underscore the significant impact the rule will have on preserving and improving the health care of veterans.

Amending the medical benefits package to allow abortion care in certain circumstances also moves VA closer toward alignment with international human rights norms in the context of sexual and reproductive rights. Human rights organizations and courts around the world recognize abortion as a fundamental human right. In its 2022 Abortion Care Guideline, the World Health Organization ("WHO") integrates international human rights law recognizing that countries must remove all legal, practical and social barriers impeding individuals' equal and non-discriminatory access to sexual and reproductive health, including abortion.[44] The Guideline also recognizes that governments have obligations to address laws, institutional arrangements, and social practices that are discriminatory and that prevent people from effective enjoyment of their right to sexual and reproductive health.

Despite these encouraging improvements, the rule could go further to ensure access to this critical health care service for all veterans. As written, the rule currently only ensures care is available in cases of rape, incest, or to protect the life or health of the pregnant person. Abortion is essential health care, no matter the reason it is sought, and medically unnecessary restrictions on abortion inherently deny pregnant people the freedom to make decisions about their social, economic, mental, and physical well-being. Moreover, given that abortion care in §17.38 and §17.272 is framed as prohibited with exceptions, we are concerned that such language may cause confusion about when and whether patients are able to obtain abortion care from VA. We urge

[39] Tristan Horrom, *Gestational Diabetes and Preeclampsia Rates Higher in Women with PTSD*, US DEPT. OF VETERANS AFFS. (Apr. 26, 2017), https://www.research.va.gov/currents/0417-pregnancy.cfm.

[40] *Id.*

[41] *Id.*

[42] Gestational diabetes alone increases the risk for pre-eclampsia in pregnant individuals, while pre-eclampsia is the leading cause of maternal mortality and of medically induced preterm delivery. Tristan Horrom, *Gestational Diabetes and Preeclampsia Rates Higher in Women with PTSD*, US DEPT. OF VETERANS AFFS. (Apr. 26, 2017), https://www.research.va.gov/currents/0417-pregnancy.cfm.

[43] 87 Fed. Reg. 55292 (Sept. 9, 2022).

[44] WORLD HEALTH ORGANIZATION, ABORTION CARE GUIDELINE 8, (Mar. 8, 2022), https://www.who.int/publications/i/item/9789240039483.

the Department to consider lifting the ban on abortion care in its entirety in the final rule and allow access to abortion for all people seeking this essential health care.

b. VA's previous abortion ban deprived veterans of essential health care and caused serious consequences for veterans in need of abortion care.

Prior to this interim final rule, VA regulations excluded all abortions from the VA's medical benefits package, making abortion unavailable in VA facilities, even to save the life of the pregnant person. CHAMPVA was similarly restrictive, banning abortion with a single exception to permit life-saving abortions for those children and spouses of veterans that are eligible for CHAMPVA. Both VA and CHAMPVA prohibited abortion counseling entirely, including referrals, forcing VA providers to turn away patients who needed their care.

There are serious health and socioeconomic consequences for patients who are denied access to abortion care, particularly for those who are denied a wanted abortion. A groundbreaking multi-year study of pregnant people seeking abortion care, led by Diana Foster Green and her team of researchers at Advancing New Standards in Reproductive Health (ANSIRH) at the University of California San Francisco, found that participants who were denied wanted abortions and forced to give birth had statistically poorer long-term health outcomes than those who accessed abortions.[45] Participants denied abortion services were more likely to experience serious complications that generally occur at the end of pregnancy, including eclampsia and death; more likely to stay tethered to abusive partners; more likely to suffer anxiety and loss of self-esteem in the short term; and less likely to have aspirational life plans for the coming year.[46] In contrast, study participants who received a wanted abortion were not only less likely to experience serious health problems than those denied a wanted abortion, but were also 50 percent more likely to set an aspirational plan and achieve it—such as finishing their education, getting a better job, giving a good life to their children, and being more financially stable—compared to participants who were denied a wanted abortion.[47]

There are also serious consequences for patients who face delays in obtaining an abortion, which are intensified for those who rely on VA for their care. As delays increase, the logistical and financial burdens multiply. VA's policies forced veterans and CHAMPVA beneficiaries to seek abortion care outside the VA system, pay for their care out of pocket, and navigate the private health care system and maze of state restrictions on abortion on their own. When a veteran or CHAMPVA beneficiary is turned away from VA without a referral, they must find a willing provider to access the health care they need. This requires spending significant time researching available providers outside the VA health care system. In areas with a limited number of health

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[45] *Turnaway Study*, ADVANCING NEW STANDARDS IN REPROD. HEALTH, https://www.ansirh.org/research/turnaway-study (last visited Oct. 1, 2022).

[46] *Id.*

[47] Ushma Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-year Plans*, 15 BMC WOMEN'S HEALTH 1, 1-10 (2015), https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-015-0259-1.

care providers, or in states that have implemented an abortion ban following the Supreme Court's overturn of *Roe v. Wade*, a veteran may need to travel long distances to access care, and incur expenses for travel, overnight stays and childcare, in addition to taking extra time off of work for the new appointment. The additional time and expense fall most heavily on low-income veterans and those without the job flexibility to take paid sick time.

For veterans and civilians alike, delays also have the effect of increasing the cost of an abortion. Abortion in the first trimester is substantially less expensive than in the second trimester: the median price of a surgical abortion at ten weeks is $508, while the cost rises to $1,195 at week 20.[48] The rising cost of abortion as gestational age increases poses a profound challenge to the affordability of the procedure, as one patient explained: "I knew the longer it took, the more money it would cost . . . We are living paycheck to paycheck as it is, and if I [had] gone one week sooner, it would have been $100 less."[49] Moreover, delays raise the cost of each step of obtaining an abortion—not just the cost of the procedure. For example, one recent study found that Utah's mandatory waiting period caused 47 percent of patients having an abortion to miss an extra day of work.[50] More than 60 percent were negatively affected in other ways, including increased transportation costs, lost wages by a family member or friend, or being required to disclose the abortion to someone whom they otherwise would not have told.[51] And because many clinics do not offer second-trimester abortions, a person 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, such as lost wages and costs for childcare.[52] As a result, health care denials that result in a delay in care can significantly drive up the cost of care for a person seeking abortion care or make it impossible altogether.

VA's prior prohibition on abortion care and even counseling compounded these obstacles civilians already face in the private marketplace when trying to access abortion care, by denying them care and information about the care they may need from the providers they trust. The rule presents a welcome change and significant improvement for veterans' and CHAMPVA beneficiaries' access to comprehensive, coordinated care.

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[48] 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, 212-218 (2018), https://www.whijournal.com/article/S1049-3867(17)30536-4/fulltext. .

[49] Sarah C.M. Roberts et al., *Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women*, 48 PERSPS. ON SEXUAL & REPROD. HEALTH 179, 184 (2016).

[50] Jessica N. Sanders et al., *The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion*, 26 WOMEN'S HEALTH ISSUES 483, 485 (2016).

[51] Jessica N. Sanders et al., *The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion*, 26 WOMEN'S HEALTH ISSUES 483, 485 (2016); Deborah Karasek et al., *Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence Before Arizona's Two-Visit 24-hour Mandatory Waiting Period Law*, 26 WOMEN'S HEALTH ISSUES 60, 60-66 (2016).

[52] Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008*?, 22 J. WOMEN'S HEALTH 706, 706-13 (2013).

IV. Conclusion.

The interim final rule is an important step toward improving the health care of veterans. We support the rule's provisions to expand access to abortion care and urge the Department to issue a strong final rule that goes further in order to ensure all veterans will be able to access this essential care. We appreciate the opportunity to comment on this interim final rule. If you require any additional information about the issues raised in this letter, please contact Freya Riedlin, Federal Policy Counsel, at friedlin@reprorights.org.

Signed,
The Center for Reproductive Rights